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| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00292807, IN00290484, and IN00289589.<br><br>This visit was in conjunction with the Investigation of Complaint IN00297610.<br><br>Complaint IN00292807-Substantiated. No deficiencies related to the allegations are cited.<br>Complaint IN00290484-Substantiated. No deficiencies related to the allegations are cited.<br>Complaint IN00289589-Substantiated. Federal/State deficiencies related to the allegations are cited at F641 and F657.<br>Complaint IN00297610-Substantiated. Federal/State deficiencies related to the allegations are cited at F697, F770, and F842.<br><br>Survey dates: June 4, 5, 6, 7, 10, and 11, 2019.<br><br>Facility number: 009569<br>Provider number: 155628<br>AIM number: 200139920<br><br>Census bed type:<br>SNF/NF: 105<br>Total: 105<br><br>Census payor type:<br>Medicare: 14<br>Medicaid: 77<br>Other: 14<br>Total: 105<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. | F 0000 | 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 of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered our credible allegation of compliance.<br>The facility respectfully requests a desk review for paper compliance in lieu of a PSR. | |

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

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| | Quality review completed on June 17, 2019 | | | |
| F 0550 SS=D Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. | | | |

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| | §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>Based on observation, interview, and record review, the facility failed to treat a resident with dignity upon entering her room for 1 of 2 residents reviewed for dignity. (Resident Z)<br><br>Findings include:<br><br>The clinical record for Resident Z was reviewed on 6/5/19 at 10:52 a.m. The diagnoses for Resident Z included, but were not limited to, heart failure, chronic obstructive pulmonary disease, major depressive disorder, and anxiety.<br><br>An interview was conducted with Resident Z on 6/5/19 at 9:40 a.m. She indicated some of the CNAs (Certified Nursing Assistants) did not treat her with respect and dignity, but was unsure of their names.<br><br>An observation was made on 6/5/19 at 9:34 a.m. in Resident Z's room. Resident Z was sitting in her wheel chair next to her bed. Resident Z pressed her call light. CNA 9 cracked the door to Resident Z's room open, looked at Resident Z, and asked, "What?" CNA 9 was queried about the skin condition on Resident Z's right ear. In the presence of Resident Z, CNA 9 responded, "What did she (Resident Z) tell you?"<br><br>An interview was conducted with Resident Z after CNA 9 left the room. She stated, "She is my CNA. When she works, she's a good CNA, when she wants to. She tries to treat me with respect and dignity, but she's one of those that when she | F 0550 | The facility will ensure this requirement is met through the following actions:<br><br>1. Individual staff counseling/staff reeducation/training initiated immediately upon.<br><br>2. All residents who reside in the facility have the potential to be affected by the alleged deficient practice.<br><br>3. The DNS/Designee will conduct staff reeducation on facility expectations of resident right and dignity.<br><br>4. To ensure compliance the Executive Director/Designee will conduct random audits of 10 residents for 5x weekly for 4 weeks. then 3x weekly for 4 weeks, then monthly until continued compliance of 100% is maintained for for 2 months. Any findings will be discussed, logged and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | 07/08/2019 |

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| | wants to, she says what she wants to say. She tries to be rude, but she cant outrude [sic] me."<br><br>The DNS (Director of Nursing Services) and Nurse Consultant were informed of the above observation on 6/7/19 at 11:34 a.m. They had no comments.<br><br>The Resident Care Procedure #01: Initial Steps was provided by the DNS on 6/10/19 at 8:46 a.m. It read, "...2. Knock and identify yourself before entering the resident's room. Wait for permission to enter the resident's room. 3. Greet resident by name per resident preference. 4. Identify yourself by name and title...."<br><br>3.1-3(a) | | | |
| F 0584 SS=E Bldg. 00 | 483.10(i)(1)-(7)<br>Safe/Clean/Comfortable/Homelike Environment<br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. | | | |

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| | §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>Based on observation, interview, and record review, the facility failed to ensure a homelike environment with residents' rooms that were clean and in good repair for 4 of 7 residents rooms observed during an environmental tour. (Resident F, K, W and Z)<br><br>Findings include:<br><br>A. An observation was made of Resident Z's room on 6/5/19 at 10:05 a.m. The bathroom was observed to have a brown substance splattered on a white toilet booster seat and dried yellow substance on a bottom blue basin in the seat riser.<br><br>B. An observation was made of Resident F's room on 6/5/19 at 10:38 a.m. Resident F's room was observed to have gouged scrapes down one side | F 0584 | The facility will ensure this requirement is met through the following actions:<br><br>1.The items listed for resident's: F, K & Z are in the process of being repaired/replaced. Resident Z's toilet riser was cleaned and sanitized immediately.<br><br>2. All residents who reside int he facility have the potential to be affected by the alleged deficient practice. An audit of all resident who have toilet risers have been completed. All toilet and risers have been cleaned accordingly. | 07/08/2019 |

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| | length of the middle and bottom wall by the bed.<br><br>C. An observation was made of Resident K's room on 6/5/19 at 11:54 a.m. The floor tiles were observed coming up underneath the bed.<br><br>D. An observation was made of Resident W's room on 6/6/19 at 10:16 a.m. The side wall was marred with white spackling and missing paint.<br><br>During an environmental tour with the Administrator, Administrator Trainee, Environmental Supervisor on 6/11/19 at 9:00 a.m., an observation was made of Resident Z's room. The bathroom was observed to have a urine odor present. A soiled brief, wash cloth and pajama bottoms were found lying on the floor. The toilet booster seat was observe on the toilet with a dry yellow substance in between the seat and toilet bowel rim. A beside commode had a basin that had dried yellow substance in it. At that time, the Environmental Supervisor indicated the soiled brief, wash cloth, and pajama bottoms should not be left on the floor. Housekeeping does remove the booster seats and clean the toilet rims. They are also to remove the basins on the bedside commodes to clean.<br><br>Resident F's room was observed during the tour with white gouged scrapes down the middle and bottom of the wall by Resident F's bed. The Administrator indicated he had been aware of the wall gouges in the room for a couple of months. After, an observation was made of Resident W's room. The wall was observed to have white spackling on 3 places of the wall. The Administrator indicated he was unaware of the wall needing painted. Then, Resident K's room was observed with floor tiles raised under the bed. The Administrator indicated at that time he was | | 3. Facility staff inservice on the appropriate way to report any environmental issues through the facility Tels system. Housekeeping staff educated on the policy and procedure for cleaning and sanitizing toilet risers.<br><br>4. To ensure compliance the Executive Director/Designee will conduct an audit 5x weekly for for 4 weeks, then 3x weekly for 4 weeks. Then monthly until continued compliance of 100% is maintained for for 2 months. Any findings will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |

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|---|---|---|---|---|
| | unaware of the floor's condition. Maintenance inspects rooms daily, and staff are able to report when rooms are in need of repair.<br><br>The "Housekeeping Services Policy" was provided by the Nurse Consultant on 6/11/19 at 11:22 a.m. It indicated "...Purpose: To ensure that the facility, equipment, furnishings and resident rooms are maintained in a sanitary manner; to provide a comfortable environment, and to prevent the development and transmission of infection...Policy: It is the policy of the facility to maintain a clean, odor free, comfortable and orderly environment in all health care and public areas, which meet the sanitation needs of the facility and residents right for a safe, clean, comfortable homelike environment..."<br><br>3.1-19(f)(5) | | | |
| F 0622 SS=D Bldg. 00 | 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br>Transfer and Discharge Requirements<br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;<br>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br>(D) The health of individuals in the facility would otherwise be endangered; | | | |

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| | (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or<br>(F) The facility ceases to operate.<br>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.<br><br>§483.15(c)(2) Documentation.<br>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.<br>(i) Documentation in the resident's medical record must include:<br>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.<br>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that | | | |

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| | cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).<br>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-<br>(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and<br>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.<br>(iii) Information provided to the receiving provider must include a minimum of the following:<br>(A) Contact information of the practitioner responsible for the care of the resident.<br>(B) Resident representative information including contact information<br>(C) Advance Directive information<br>(D) All special instructions or precautions for ongoing care, as appropriate.<br>(E) Comprehensive care plan goals;<br>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. | | | |
| | Based on interview and record review the facility failed to provide transfer form and information upon discharge and ensure the information provided to the receiving provider included residents medication administration record for 2 of 2 residents reviewed for hospitalizations (Residents C and G).<br><br>Findings include:<br><br>1. The clinical record for Resident C was reviewed on 6/5/2019 at 10:33 a.m. The diagnosis for | F 0622 | The facility will ensure this requirement is met through the following actions:<br><br>1. Resident C and Resident G no longer resident at the facility<br><br>2. All residents who discharge from the facility unplanned have the potential to be affected by the alleged deficient practice. | 07/08/2019 |

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| | Resident C included, but were not limited to, acute kidney failure.<br><br>The clinical record contained a nurse's note dated 5/23/2019 at 2:41 p.m., indicating Resident C was to be sent to an acute care hospital per the family's request.<br><br>A notice of transfer or discharge form, dated 5/23/2019, was located in the clinical record. It indicated that transfer or discharge was necessary to meet the resident's welfare and the resident's needs cannot be met in the facility.<br><br>The clinical record did not contain a transfer form or documentation about what information was sent with Resident C to the acute care hospital.<br><br>During an interview on 6/11/2019 at 12:08 p.m., the ADNS (Assisted Director of Nursing Services) indicated that a transfer form was not initiated for Resident C. She indicated there was no documentation available about what was sent with him to the acute care hospital.<br><br>On 6/11/2019 at 12:55 p.m., the Nurse Consultant provided the Notice of Transfer or Discharge policy which read as follows: "Policy: It is the policy of this facility to assist the residents as directed by the Administrator should a Notice of Transfer or Discharge become necessary... Procedure: 7. when the facility transfers or discharges a resident under any circumstances the facility must ensure that the transfer or discharge is documented in the medical record and the appropriate information is communicated with the receiving healthcare institution or provider. Documentation will include: ... e. The following information must be sent to the receiving facility: i. Contact information of the | | 3. The DNS/Designee will conduct an inservice with licensed nursing staff on transfer/discharge policy and facility expectation of documentation.<br><br>4. To ensure compliance the DNS/Designee will conduct an audit 5x weekly of all transfers to ensure the notice of transfer and discharge policy was followed. The audit will be completed 5x weekly for 2 weeks, then 3x weekly for 2 weeks, then 2x weekly for 4 weeks, then monthly until continued compliance of 100% is maintained for for 2 months. Any findings will be discussed, logged and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |

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| | practitioner responsible for care. ii. Resident representative information including contact information. iii. Advanced Directive information. iv. All special instructions or precautions for ongoing care. v. Comprehensive care plan goals. vi. All other necessary information including a copy of the resident transfer information, a resident discharge summary, and any other documentation to ensure a safe transition of care..."2. A progress note on 8/13/18 at 13:36 p.m. indicated the nurse received a new order from the Nurse Practitioner (NP) for resident G to be sent to the hospital for evaluation and treatment for possible fistula (an abnormal passage between a hollow or tubular organ and the body surface, or between two hollow or tubular organs) and evaluation of a wound to her right lower extremity.<br><br>A record review on 6/10/19 at 11:29 a.m., indicated an Interact Transfer Form was completed for resident G on 8/13/18 and included the following information: resident representative contact information; advance directive information; special risks for falls; resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; diagnoses and allergies. The form did not include resident G's medication administration record.<br><br>An interview with Director of Nursing Services (DNS) and the Nurse Consultant (NC) on 06/11/19 at 8:50 a.m. indicated it is the responsibility of Medical Records (MR) to scan the medication administration record onto the Interact Transfer Form as to provide verification that a medication administration sheet was sent with resident to the ER however, the MR designee, at that time, did not scan in the medication sheet into chart. DNS indicated this is why the facility is unable to | | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 |
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| | produce verification of the inclusion of resident G's medication list and administration record to the receiving provider. DNS indicated the medication list and medication administration record must be included when transferring a resident for any reason.<br><br>A Notice of Transfer or Discharge policy received on 6/11/19 states, "....7. When the facility transfers or discharges a resident under any circumstances, the facility must ensure that the transfer or discharge...the appropriate information is communicated with the receiving healthcare institution or provider. Documentation will include...vi. All other necessary information including a copy of the resident transfer information, a resident discharge summary, and any other documentation to ensure a safe transition of care..."<br><br>3.1-50<br>3.1-12(a) (3) | | | |
| F 0636<br>SS=D<br>Bldg. 00 | 483.20(b)(1)(2)(i)(iii)<br>Comprehensive Assessments & Timing<br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

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|---|---|---|---|---|
| | (i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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|---|---|---|---|---|
| | or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>Based on interview and record review, the facility failed to complete an Admission MDS (Minimum Data Set) assessment timely for 1 of 3 residents reviewed for resident assessment. (Resident 3)<br><br>Findings include:<br><br>The clinical record for Resident 3 was reviewed on 6/10/19 at 11:41 a.m. The diagnoses for Resident 3 included, but were not limited to, atrial fibrillation and dementia. She was admitted to the facility on 12/20/19.<br><br>Resident 3's 12/27/18 Admission MDS assessment was completed on 1/4/19, fifteen days after her admission.<br><br>An interview was conducted with the Regional MDS Support via telephone on 6/10/19 at 12:22 p.m. He indicated the time frame for completion was 14 days after admission. He indicated he found there were many MDS assessments open, but not completed, so as a result, they were completed late.<br><br>An interview was conducted with the Nurse Consultant on 6/10/19 at 12:30 p.m. She indicated the facility used the RAI (Resident Assessment Instrument) manual as their MDS policy.<br><br>The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.16 from October 2018 indicated the completion date for an Admission MDS assessment was no later than the 14th calendar | F 0636 | The facility will ensure this requirement is met through the following actions:<br>1. The timeliness of the MDS admission assessment was identified prior to this survey process. The MDS in question had been corrected and completed according the RAI guidelines; and a change in the MDS personnel took place prior to this survey.<br>2. All residents who admit to the facility have the potential to be affected by the alleged deficient practice.<br>3. The MDS team have been educated on scheduling and completion of the MDS schedule according the RAI guidelines<br><br>4. To ensure compliance, the Regional MDS Consultant/Designee will audits 3 MDS admission assessments for timeliness weekly for 2 months until 100 % compliance is achieved, then monthly for 3 months and until 100% compliance is achieved. Any finding will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the | 07/08/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

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|---|---|---|---|---|
| | day of the resident's admission (admission date + 13 calendar days.)<br><br>3.1-31(d) | | reviews will be adjusted as needed. | |
| F 0638 SS=D Bldg. 00 | 483.20(c)<br>Qrtly Assessment at Least Every 3 Months<br>§483.20(c) Quarterly Review Assessment<br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br>Based on interview and record review, the facility failed to complete a Quarterly MDS (Minimum Data Set) assessment timely for 1 of 3 residents reviewed for resident assessment. (Resident 4)<br><br>Findings include:<br><br>The clinical record for Resident 4 was reviewed on 6/10/19 at 11:44 a.m. The diagnoses for Resident 3 included, but were not limited to, hypertension and depression.<br><br>Resident 4 had a Quarterly MDS assessment dated 1/11/19. Her next Quarterly MDS assessment was dated 4/10/19 with an ARD (assessment reference date) of 4/10/19. The 4/10/19 Quarterly MDS assessment was completed 5/30/19.<br><br>An interview was conducted with the Regional MDS Support via telephone on 6/10/19 at 12:22 p.m. He indicated the time frame for completion of a Quarterly MDS assessment was 14 days. He indicated he found there were many MDS assessments open, but not completed, so as a result, they were completed late.<br><br>An interview was conducted with the Nurse | F 0638 | =”” span=””><br>To facility will ensure this requirement is met through the following actions:<br>1. The timeliness of the MDS quarterly assessment was identified prior to this survey process. The MDS in question had been corrected and completed according the RAI guidelines; and a change in the MDS personnel took place prior to this survey.<br>2. All residents who reside at the facility have the potential to be affected by the alleged deficient practice.<br>3. The MDS team have been educated on scheduling and completion of the MDS schedule according the RAI guidelines 4,<br>To ensure compliance, the Regional MDS Consultant/Designee will audits 3 MDS quarterly assessments for timeliness weekly for 2 months until 1000 % compliance is achieved, then monthly for 3 | 07/08/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

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|---|---|---|---|---|
| | Consultant on 6/10/19 at 12:30 p.m. She indicated the facility used the RAI (Resident Assessment Instrument) manual as their MDS policy.<br><br>The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.16 from October 2018 indicated the completion date for a Quarterly MDS assessment was the assessment reference date plus 14 calendar days.<br><br>3.1-31(d)(3) | | months and until 100% compliance is achieved. Any finding will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |
| F 0641<br>SS=D<br>Bldg. 00 | 483.20(g)<br>Accuracy of Assessments<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>Based on interview and record review, the facility failed to ensure accuracy of a residents' MDS (Minimum Data Set) assessments regarding a PASRR Level II and hospice services for 2 of 23 residents reviewed for MDS Assessment accuracy (Residents T and Z).<br><br>Findings include:<br><br>1. The clinical record for Resident Z was reviewed on 6/5/19 at 10:52 a.m. The diagnoses for Resident Z included, but were not limited to, major depressive disorder.<br><br>The 6/21/18 PASRR (Pre Admission Screening Resident Review) Level II for Resident Z read, "DEFINITION OF MENTAL ILLNESS An individual is considered to have mental illness if he/she has a current primary or secondary diagnosis of a major mental disorder (as defined in the current Diagnostic and Statistical Manual of Mental Disorders) limited to schizophrenia, | F 0641 | The facility will ensure this requirement is met through the following actions:<br><br>1. Resident T no longer resides at the facility. Resident Z's 4/15/19 significant change assessment for resident Z has been modified and resubmitted.<br>2. All residents have the potential to be affected. See below for corrective measures.<br>3. The MDS team have been educated on scheduling and accurate completion of the MDS schedule according the RAI guidelines, which is the facilities guide for practice.<br>4. To ensure compliance, the Regional MDS consultant will audit 10 MDS's per month for accuracy until 2 consecutive | 07/08/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

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|---|---|---|---|---|
| | schizoaffective, mood (bipolar and major depressive type), paranoid or delusional..." The Level II indicated Resident Z had a diagnosis of recurrent major depressive disorder, and was mentally ill as defined above.<br><br>The 4/5/19 Significant Change MDS assessment for Resident Z indicated she had not been evaluated by the state Level II process and determined to have a serious mental illness.<br><br>An interview was conducted with the MDS Coordinator on 6/10/19 at 12:23 p.m. He reviewed Resident Z's 6/21/18 PASRR Level II assessment and indicated he understood why her 4/5/19 Significant Change MDS assessment was inaccurate.<br><br>An interview was conducted with the Nurse Consultant on 6/10/19 at 12:30 p.m. She indicated the facility used the RAI (Resident Assessment Instrument) manual as their MDS policy.<br><br>The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.16 from October 2018 indicated to code yes if a PASRR Level II screening determined that the resident had a serious mental illness.<br>2. The clinical record for Resident T was reviewed on 6/10/2019 at 9:06 a.m. The diagnosis for Resident T included, but were not limited to, femoral fracture.<br><br>The clinical record contained a physician's order dated 12/28/2018, indicating Resident T was to be admitted to hospice services.<br><br>The clinical record contained a Significant Change of Status MDS (Minimum Data Set) Assessment which was completed on 1/2/2019. The MDS | | months of 100% compliance is achieved then quarterly until 100% compliance is achieved. Any finding will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

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|---|---|---|---|---|
| | assessment did not indicate that Resident T was receiving hospice services.<br><br>During an interview on 6/11/2019 at 9:35 a.m., the Regional MDS Support Consultant indicated that the Significant Change of Status MDS, completed 1/2/2019, was coded incorrectly and that hospice services should included on the MDS.<br><br>This Federal Tag relates to Complaint IN00289589. | | | |
| F 0656 SS=D Bldg. 00 | 483.21(b)(1)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

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|---|---|---|---|---|
| | the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. | | | |
| | Based on observation, interview and record review, the facility failed to implement the comprehensive person-centered care plan for the floating of resident's heels for 1 of 1 residents being reviewed for pressure ulcer/ injury. (Resident W)<br><br>Findings include:<br><br>An observation on 6/6/19 at 10:20 a.m., of resident W in bed wearing a hospital gown. Resident was on a pressure relieving mattress. Resident W's heels were witnessed to be resting on the mattress.<br><br>An observation on 6/10/19 at 9:43 a.m., of resident W in bed with her feet exposed and her heels resting directly on the mattress.<br><br>A record review completed on 6/10/19 at 9:49 a.m. indicated an order for resident W's heels to be floated (not touching the mattress) while in bed written on 11/28/18. | F 0656 | The facility will ensure this requirement is met through the following actions:<br><br>1. Resident W had no negative effects related to the alleged deficient practice.<br><br>2. All residents have the potential to be affected. The plan of care for all residents who require a splint have been reviewed and updated accordingly.<br><br>3. The DNS and/or designee will conduct nursing staff reeducation on resident care plan interventions<br><br>3. To ensure compliance, the DNS and or/Designee will complete random audits for 5 residents who require their heels to be floated while in bed. The random audits | 07/08/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

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|---|---|---|---|---|
| | Resident W's diagnosis, included but not limited to, cognitive communication deficit, muscle weakness, reduced mobility, dementia and diabetic neuropathy.<br><br>The Quarterly Minimum Data Sheet (MDS) dated 5/14/19 indicated resident W required extensive assistance of 2 people for bed mobility, transfers, dressing and personal hygiene.<br><br>The care plan states, "I am at risk for developing pressure ulcers related to , requires assistance with bed mobility, toileting and transfers, diabetic, Alzheimer's Dementia, history of pressure ulcers, incontinence. My risk will be minimized through my care plan interventions by no skin breakdown. I will have a cushion in my chair. I will rest on a special support surface such as low air loss, alternating air mattress, mosaic/roho mattress, etc. I will turn and reposition frequently and ask for assistance as needed. You will apply skin prep barrier to bilateral heels. You will float my heels when I am in bed"<br><br>An interview on 06/11/19 at 9:22 a.m. with UM 2 indicated, on two separate days the resident was observed not to have her heels floated while in bed. UM 2 indicated the resident has a care plan with an intervention to float the heels and her heels should be floated in bed at all times.<br><br>3.1-35 | | will be completed 5x weekly for 6 weeks, then 2 times a week for 4 weeks, then monthly until continued compliance of 100% is maintained for 2 months. Any finding will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment. | | | |

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|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

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|---|---|---|---|---|
| | (ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br><br>Based on interview and record review the facility failed to assure a care plan was updated to include a fractured hip and arm for 1 of 3 discharge residents reviewed ( Resident T)<br><br>Findings include:<br><br>The clinical record for Resident T was reviewed on 6/10/2019 at 9:06 a.m. The diagnosis for Resident T included, but were not limited to, multiple myeloma and femoral fracture.<br><br>The clinical record contained a progress note dated 12/27/2018 at 3: 54 p.m., indicating resident T was treated at an acute care hospital for a | F 0657 | The facility will ensure this requirement is met through the following actions:<br><br>1. Resident T no longer resides at the facility.<br><br>2. All residents have the potential to be affected. The plan of care for all residents who have had a change of condition over the past 30 days were reviewed and care plans were updated accordingly.<br><br>3. The DNS and/or designee will conduct nursing staff reeducation | 07/08/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

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|---|---|---|---|---|
| | pathologic femur fracture.<br><br>The clinical record contained a progress note date 12/28/2018 at 12:37 p.m., indicated Resident T complained of left shoulder pain and a physician's order was received for a x-ray.<br><br>A progress note dated 12/29/2018 at 12:26 p.m., indicated left shoulder X ray results indicated a suspected left shoulder fracture due to malignancy.<br><br>The clinical record did not contain a care plan addressing Resident T's fractured left femur or left shoulder.<br><br>During an interview on 6/11/2019 at 9:54 a.m., the Nurse Consultant indicated the care plan should have been updated to include Resident T's fractures.<br><br>On 6/11/2019 at 11:20 a.m., the Nurse Consultant provide the Care Planning Policy which reads as follows: " Policy: It is the policy of this facility to develop a comprehensive plan of care that is individualized, and reflective of the resident's goals, preferences and services that are to be provided to attain or maintain the resident's highest practical physical, mental, and psychosocial well- being... 17. Care plans will be updated with any changes in the resident orders, care and services that change the plan of care..."<br><br>This Federal Tag relates to Complaint IN00289589.<br><br>3.1-35(d) (2) (B) | | on resident change of condition care plan revisions.<br><br>4. To ensure compliance, the DNS and or/Designee will complete random audits for 5 residents who have had a change in condition. The random audits will be completed 5x weekly for 6 weeks, then 2 times a week for 4 weeks, then monthly until continued compliance of 100% is maintained for 2 months. Any finding will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 |
|---|---|---|---|---|
| | Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on observation, interview, and record review, the facility failed to recognize and address a resident's skin condition of her right ear and her missing hearing aids for 1 of 2 residents reviewed for skin conditions and 1 of 3 residents reviewed for communication and sensory. (Resident Z)<br><br>Findings include:<br><br>1. a) The clinical record for Resident Z was reviewed on 6/5/19 at 10:52 a.m. The diagnoses for Resident Z included, but were not limited to, heart failure, chronic obstructive pulmonary disease, major depressive disorder, and anxiety.<br><br>The activities of daily living care plan for Resident Z, revised 4/12/19, indicated she needed assistance with morning and evening care, extensive physical assistance of one for bed mobility, physical assistance of one staff for dressing, and extensive physical assistance of 1 to 2 staff for transfers and bed mobility.<br><br>The pressure ulcer care plan for Resident Z, revised 4/11/19, indicated for her skin to be observed weekly and as needed.<br><br>The skin integrity care plan for Resident Z, revised 4/11/19, indicated an intervention was for staff to assist her as needed to keep her skin clean and dry. | F 0684 | The facility will ensure this requirement is met through the following actions:<br><br>1. Residentsassessed immediately upon surveyor's report. Resident reports she scratched her ear and caused it to bleed. Residents MD and family made aware of resident change. Resident's orders updated to reflect check placement for scopolamine patch every shift. Plan of care reviewed and updated to reflect current schedule for weekly skin assessments. Audiology provider notified and resident will be seen upon next visit.<br><br>2. All residents have the potential to be affected. All resident shower schedules were reviewed to ensure they were current. All resident who require a hearing device were to make sure they have their hearing device and that the device is functioning. .<br><br>3. The DNS and/or designee will conduct nursing staff reeducation | 07/08/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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|---|---|---|---|---|
| | An observation of Resident Z's right ear was made on 6/4/19 at 2:32 p.m. during a Resident Council meeting. There was an open area in the middle of her outer ear, with redness. There was no dressing on her ear.<br><br>An observation of Resident Z's right ear was made on 6/5/19 at 9:34 a.m. in her room. Resident Z was dressed and in her wheel chair. The open area on her ear was red and bloody with a small piece of toilet paper stuck to the area. Blood had seeped through the toilet paper.<br><br>An interview was conducted with Resident Z on 6/5/19 at 9:34 a.m. She indicated she was on some sort of medication applied to her ear for 3 days that was causing her to "break out." She indicated she put toilet paper on her ear, because it was bleeding and had been bleeding since the previous day.<br><br>On 6/5/19 at 9:58 a.m., during the above interview with Resident Z, CNA (Certified Nursing Assistant) 9 entered Resident Z's room, indicated she was unaware of what was going on with Resident Z's right ear and suggested the nurse may know.<br><br>On 6/5/19 at 10:12 a.m., an interview was conducted with LPN (Licensed Practical Nurse) 10 in Resident Z's room. LPN 10 observed Resident Z's right ear and stated, "I didn't know her ear looked like that." LPN 10 indicated Resident Z had a Scopolamine patch, used for secretions, applied behind her ear every 3 days. There was no Scopolamine patch behind either of Resident Z's ears at this time. The toilet paper was removed from Resident Z's ear. Her ear had a red scab with dried blood around it. LPN 10 indicated she was | | on the following: adding orders to check placement of medication patches every shift, implementing resident weekly skin assessments schedule upon admission/readmission, and reporting to social service if a resident misplaces or loses their hearing device. A communication binder will be placed at each nurses station. The Interdisciplinary Team (IDT) shall conduct a huddle on each unit reviewing all residents with direct caregivers, asking about referrals needed for Audiology/Podiatry/Vision/Dental services. Social Services will then notify the ancillary provider of the service needs and ensure residents are seen.<br><br>4. To ensure compliance, the DNS and or/Designee will complete an audits for 5 residents who have had a patch to check for placement. The audit will be completed 5x weekly for 6 weeks, then 2 times a week for 4 weeks, then monthly until continued compliance of 100% is maintained for 2 months. DNS and or /Designee will audit 3 admission/readmission weekly x 6 weeks to ensure the weekly skin assessment schedule has been implemented. The audit will be completed 5x weekly for 6 weeks, then 2 times a week for 4 weeks, then monthly until | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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|---|---|---|---|---|
| | going to get an order for Resident Z's ear.<br><br>An interview was conducted with Resident Z on 6/5/19 at 10:18 p.m. in the presence of LPN 10. Resident Z indicated the Scopolamine patch fell off 2 days earlier, but she didn't tell nursing, because she did not want to wear the patch. LPN 10 indicated nursing should be checking the placement of the Scopolamine patch every shift.<br><br>The June, 2019 physician's orders for Resident Z indicated for a Scopolamine patch to be applied every 3 days for secretions. There was no order to check the placement of the patch.<br><br>The last skin assessment in Resident Z's clinical record was dated 3/20/19.<br><br>An observation was made and interview conducted with Resident Z on 6/7/19 at 9:55 a.m. She was in bed in her room. There was no dressing on her ear, and she was not wearing a Scopolamine patch. Resident Z indicated nursing had not applied any medication to her ear.<br><br>An interview was conducted with LPN 10 and UM (Unit Manager) 2 on 6/7/19 at 9:56 a.m. LPN 10 indicated she called the physician and got an order for bacitracin to Resident Z's right ear, and informed the physician about Resident Z's concerns regarding her Scopolamine patch. LPN 10 and UM 2 reviewed Resident Z's physician's orders, but were unable to locate an order for Resident Z's right ear. UM 2 indicated skin assessments were to be done weekly and documented in the assessments portion of the electronic health record. UM 2 reviewed Resident Z's assessments and indicated the last skin assessment was dated 3/20/19. Resident Z's progress notes were reviewed at this time, and | | continued compliance of 100% is maintained for 2 months. The Executive Director or his/her designee will attend IDT huddles and review audiology list weekly (to be seen and seen) for 8 weeks and until 2 consecutive audiology visits with no omissions and continue to review audiology lists and visits for 6 months and until 3 consecutive visits of 100% compliance is achieved. Any finding will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |

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|---|---|---|---|---|

there was no reference to Resident Z's right ear skin condition.

An interview was conducted with the DNS (Director of Nursing Services) on 6/10/19 at 10:20 a.m. She indicated Resident Z did not realize what the Scopolamine patch was for, so they educated her on the purpose. She indicated she was unaware the patch wasn't on for 2 days and stated, "It wouldn't hurt to check the placement."

The Weekly Skin Observations policy was provided by the DNS on 6/7/19 at 3:40 p.m. It read, "It is the policy of this facility to observe residents' skin condition twice weekly during showers and once weekly by licensed nurse and report and document anything abnormal."

1. b) The clinical record for Resident Z was reviewed on 6/5/19 at 10:52 a.m. The diagnoses for Resident Z included, but were not limited to, heart failure, chronic obstructive pulmonary disease, major depressive disorder, and anxiety.

The activities of daily living care plan for Resident Z, revised 4/12/19, indicated she needed assistance with morning and evening care, extensive physical assistance of one for bed mobility, physical assistance of one staff for dressing, and extensive physical assistance of 1 to 2 staff for transfers and bed mobility.

The 9/17/18 Significant Change MDS assessment and 12/10/18 Quarterly MDS assessment indicated Resident Z's hearing was adequate and no appliance was used during the assessments. The 1/25/19 Quarterly MDS assessment and the 4/5/19 Significant Change MDS (Minimum Data Set) assessment indicated Resident Z had minimal difficulty hearing and a hearing aid was used

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
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|---|---|---|---|---|
| | during the assessments.<br><br>An observation of Resident Z was made on 6/4/19 at 2:32 p.m. during a Resident Council meeting. She was not wearing hearing aids in her ears.<br><br>An observation was made and interview was conducted with Resident Z on 6/5/19 at 9:54 a.m. in her wheel chair in her room. Her television was on loudly upon entrance to her room. She indicated she was supposed to have 2 hearing aides, but they were lost and had been for a year. She indicated she had a hard time hearing her television and had to have it on loudly. She was not wearing any hearing aids at this time.<br><br>An observation of Resident Z was made on 6/7/19 at 10:34 a.m. She was not wearing hearing aids in her ears. She indicated she needed assistance putting the hearing aids in and would wear them if she had them.<br><br>The 7/26/18 audiology consult indicated Resident Z's hearing aids were reported missing, but nursing found 2 hearing aids in the medication cart. Both items were checked and working, so no replacements were needed at this time.<br><br>An observation of Resident Z's room was made with CNA (Certified Nursing Assistant) 13 on 6/7/19 at 10:44 a.m. CNA 10 looked around Resident Z's room and through some of her belongings for her hearing aids, but was unable to locate them.<br><br>An interview was conducted with SSD (Social Services Director) 11 and SSD 12 on 6/7/19 at 10:50 a.m. SSD 12 indicated they were going to check the medication cart for Resident Z's hearing aids. | | | |

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|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
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|---|---|---|---|---|
| | An observation of the 200 hall medication cart was made with SSD 11, SSD 12, Unit Manager (UM) 2, and LPN (Licensed Practical Nurse) 10 on 6/7/19 at 10:51 a.m. Resident Z's hearing aids were not found in the cart.<br><br>An observation of UM 2, SSD 11, SSD 12, and LPN 10 looking through Resident Z's room and belongings was made on 6/7/19 at 10:57 a.m. They were unable to locate her hearing aids.<br><br>An interview was conducted with the DNS (Director of Nursing Services) on 6/7/19 at 11:34 a.m. She indicated she expected nursing to have recognized Resident Z's hearing aides were missing, since she required assistance for ADL care.<br><br>3.1-37(a) | | | |
| F 0688 SS=D Bldg. 00 | 483.25(c)(1)-(3)<br>Increase/Prevent Decrease in ROM/Mobility<br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility | | | |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| | with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>Based on observation, interview, and record review, the facility failed to ensure a splint was worn per the plan of care on 1 of 2 residents reviewed for range of motion. (Resident H)<br><br>Findings include:<br><br>The clinical record for Resident H was reviewed on 6/5/19 at 10:29 a.m. The diagnoses for Resident H included, stroke.<br><br>A quarterly 2/28/19 Minimal Data Set (MDS) assessment indicated Resident H was cognitively intact with impairment on one side of her upper extremity.<br><br>A care plan dated 1/18/19 for Resident H indicated "I (Resident H) need wear my left hand splint during the overnight...Interventions..I will wear left hand splint and edema glove overnight while sleeping and will keep arm raised.."<br><br>A "Therapy Referral for Restorative Nursing/Functional Maintenance Program" form for Resident H indicated "...Current Functional Status: Pt (patient) tolerates wearing left hand splint for up to 8 hours..Problems/Needs: Pt needs to wear splint for safe hand positioning during sleep..Goals: Pt to wear L (left) hand splint overnight...Recommendations/Approaches: (To include devices, equipment, strategies) wear edema glove while wearing splint and keep arm raised.."<br><br>An observation was of Resident H on 6/11/19 at 5:50 a.m. Resident H was in bed with eyes closed, and there was no observation of edema glove or | F 0688 | The facility will ensure this requirement is met through the following actions:<br><br>1. Resident H had no negative effects related to the alleged deficient practice.<br><br>2. All residents who require a splint have the potential to be affected. All residents who have a functional maintenance plan (FMP) for a splint was reviewed. All residents who require a splint were audited and all were in place. Residents will continue to be screened by therapy quarterly and as needed to identify if there is a decrease in Range of Motion/Mobility. Any resident noted to have a decrease in Range of Motion/Mobility will be referred to the appropriate therapies as needed to meet the needs of the residents and maintain their highest level of function and independence.<br><br>3. Policy reviewed and no changes were necessary at this time. Nursing staff educated on the importance of applying splints as outlined in the resident specific FMP.<br><br>4. To ensure compliance, the DON/Designee will audit of 5 | 07/08/2019 |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| | splint on her left hand.<br><br>An interview was conducted with Resident H on 6/5/19 at 10:34 a.m. She indicated she was suppose to wear a hand splint at night on her left hand, but the staff forgets to put it on.<br><br>An interview was conducted with Occupational Therapist 20 on 6/10/19 at 4:49 p.m. She indicated the<br>Therapy Referral for Restorative Nursing/Functional Maintenance Program forms were provided by the therapy department to the nursing staff with what needed to be done for a resident. Education at that time would be provided to the nursing staff on what to do and how to apply devices if needed.<br><br>An interview was conducted with Registered Nurse 9 on 6/11/19 at 6:23 a.m. She indicated Resident H did have a splint that was suppose to be worn at night, but the staff had not put it on that night.<br><br>3.1-42(a)(2) | | residents weekly who have a FMP for splinting. An audit will be completed weekly for 8 weeks until 100% compliance is achieved, then 5 per month for 3 months and until 2 consecutive months of 100% compliance is achieved. Any finding will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |
| F 0697<br>SS=E<br>Bldg. 00 | 483.25(k)<br>Pain Management<br>§483.25(k) Pain Management.<br>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.<br>Based on interview and record review, the facility failed to ensure pain evaluations were obtained prior to and after the administration of as needed (PRN) pain medication and administer pain medication as ordered for 3 of 5 residents | F 0697 | The facility will ensure this requirement is met through the following actions:<br><br>1. No residents who reside in the | 07/08/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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|---|---|
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|---|---|---|---|---|
| | reviewed for unnecessary medications and 2 of 4 residents reviewed for pain. (Resident B, D, E, F, and R)<br><br>Findings include:<br><br>1. The clinical record for Resident D was reviewed on 6/11/19 at 9:16 a.m. The diagnoses for Resident D included, but were not limited to, chronic pain and neuropathy.<br><br>The June, 2019 physician's orders indicated Norco 10-325 mg tablets to be given every 6 hours, as needed, for neuropathic pain.<br><br>The narcotic log for the above medication indicated the PRN Norco was administered 15 times between 5/5/19 and 6/6/19.<br><br>The May and June, 2019 MARs (medication administration records) and progress notes did not include pain assessments for the 15 administrations.<br><br>An interview was conducted with the DNS (Director of Nursing Services) on 6/11/19 at 10:45 a.m. She indicated nursing should have done pain assessments for the PRN Norco administrations and documented them on the MAR.2. The clinical record for Resident F was reviewed on 6/10/19 at 9:00 a.m. The diagnoses for Resident F included, but was not limited to end stage kidney disease.<br><br>A physician order dated 6/26/18 indicated Resident F was to receive scheduled 5-325 milligrams of hydrocodone-acteminophen every 6 hours for pain.<br><br>The May 2019 narcotic tracking record indicated Resident F received 5-325 milligrams of | | facility were negatively affected by the alleged deficient practice.<br><br>2. All residents who receive PRN pain medication have the potential to be affected by the alleged deficient practice.<br><br>3. Policy reviewed and no changes were necessary at this time. Nursing staff educated to perform pain assessments prior to and after administration of PRN pain meds and following physician orders related to pain medication.<br><br>4. DON/Designee will audit routine pain medication administration andd PRN medications administered for pain assessments 5 times weekly for 4 weeks, then 4 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then weekly for 4 weeks for 2 months until 100% compliance is achieved. Any findings will be discussed, logged and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |

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|---|---|---|---|---|
| | hydrocondone-acteminophen prior to every 6 hours as ordered on the following days and times:<br>5/11/19 at 8:00 p.m.,<br>5/12/19 at 12:00 a.m., (administered in 4 hours from last dose)<br>5/12/19 at 9:00 p.m.,<br>5/13/19 at 12:00 a.m., (administered in 3 hours from last dose)<br>5/20/19 at 8:00 p.m.,<br>5/21/19 at 12:00 a.m., (administered in 4 hours from last dose)<br>5/26/19 at 10:00 p.m.,<br>5/27/10 at 12:00 a.m., (administered in 2 hours from last dose)<br><br>3. a) The clinical record for Resident E was reviewed on 6/10/19 at 9:37 a.m. The diagnoses for Resident E included, but was not limited to long term use of anticoagulants.<br><br>A physician order dated 4/8/19 indicated Resident E was to receive 7.5-325 milligrams of norco every 12 hours PRN for pain.<br><br>The May 2019 Medication Administration Record (MAR) indicated Resident E received the PRN 7.5-325 milligrams of norco on the following days with pain evaluations:<br>5/2/19 - 7:21 p.m., - Resident E's pain level 3 and PRN medication was effective, and<br>5/21/19 - 9:31 a.m., - Resident E's pain level 4 and PRN medication was effective<br><br>A May 2019 narcotic tracking record indicated Resident E received the PRN 7.5-325 milligrams of norco on the following additional days that were not recorded on the May 2019 MAR:<br>5/1/19 at 9:00 p.m.,<br>5/10/19 at 9:00 p.m.,<br>5/13/19 at 9:00 a.m., | | | |

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| | 5/14/19 at 9:00 a.m.,<br>5/15/19 at 10:00 a.m.,<br>5/15/19 at 9:00 p.m.,<br>5/16/19 at 7:42 a.m.,<br>5/17/19 at 9:00 a.m.,<br>5/17/19 at 9:00 p.m.,<br>5/18/19 at 2:00 p.m.,<br>5/20/19 at 9:00 a.m.,<br>5/20/19 at 9:00 p.m.,<br>5/22/19 at 9:00 p.m.,<br>5/24/19 at 5:00 p.m.,<br>5/24/19 at 5:00 p.m.,<br>5/28/19 at 9:00 p.m., and<br>5/29/19 at 9:00 p.m.,<br><br>The June 2019 Medication Administration Record (MAR) indicated Resident E received the PRN 7.5-325 milligrams of norco on the following days with pain evaluations:<br>6/1/19 - 7:53 a.m., - Resident E's pain level 7 and PRN medication was effective, and<br>6/6/19 - 4:06 a.m., - Resident E's pain level 6 and PRN medication was effective<br><br>A June 2019 narcotic tracking record indicated Resident E received the PRN 7.5-325 milligrams of norco on the following additional days that were not recorded on the May 2019 MAR:<br>6/1/19 - 9:00 p.m.,<br>6/2/19 - 9:00 p.m., and<br>6/3/19 - 9:00 p.m.<br><br>There was no documentation in the clinical record Resident E's pain was evaluated prior or after the additional PRN norco administrations that were recorded on the May 2019 or June 2019 narcotic records.<br><br>3. b) The April 2019 narcotic tracking record indicated Resident E received 7.5-325 milligrams of | | | |

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| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| | PRN norco prior to every 12 hours as ordered on the following days and times:<br><br>4/27/19 at 9:00 p.m., was given 1 tab,<br>4/27/19 at 9:00 p.m., was given 1 tab, (two dose administration)<br>4/29/19 at 3:00 a.m., was given 1 tab,<br>4/29/19 at 9:00 a.m., was given 1 tab, (administered in 6 hours of last dose)<br><br>The May 2019 narcotic tracking record indicated Resident E received 7.5-325 milligrams of PRN norco prior to every 12 hours as ordered on the following days and times:<br><br>5/24/19 at 5:00 p.m., was given 1 tab, and<br>5/24/19 at 5:00 p.m., was given 1 tab (two dose administration)<br><br>An interview was conducted with the Director of Nursing Services (DNS) on 6/10/19 at 4:32 p.m. She indicated the residents' pain level should be evaluated and effectiveness after administration of PRN medication. She could not determine the cause of the duplication of the pain medication on 4/27/19 and 5/24/19.<br><br>An interview was conducted with the Nurse Consultant on 6/11/19 at 11:41 a.m. She was unsure the reason the administration of the pain medications for Resident E and Resident F were administered prior to the timeframe as ordered.<br><br>A "Pain Evaluation" policy was provided on 6/11/19 at 10:44 a.m. It indicated "..Purpose: To establish guidelines to measure a resident's level of pain. To provide optimal comfort through a pain control plan, which is established with the members of the health care team....3. Residents will have pain assessed routinely with each dose of | | | |

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| | pain medication given....4. A resident with cognitive impairment who is unable to verbalize pain will have the PAINAD completed. 5. The resident will be asked to use a pain scale to rate their level of pain both on the evaluation and with the administration of pain medications...6. Nursing will document any complaints or signs/symptoms of pain in the progress notes at indicated. 7. The pain scale will be used to determine the effectiveness of pain interventions.<br><br>A "PRN Medication Administration Documentation Protocol" was provided by the Nurse Consultant on 6/11/19 at 10:44 a.m. It indicated "..PRN Medication is to be documented at the time of administration. The nurse (QMA (Qualified Nursing Assistant), where applicable) will document the administration of the medication in the eMAR (electronic medication record). A progress note will be completed, which will include the reason the resident is receiving the PRN medication...A follow up progress note will be required for all PRN medications that include the effectiveness of the PRN medication.<br><br>A "Following Medication-Physician Orders/Parameters" policy was provided on 6/11/19 at 10:44 a.m. It indicated "Purpose: To administer medications in a safe and effective manner and following physician order parameters...Procedures: ..Review 5 Rights (3) times: 1) Prior to removing the medication package/container from the cart/drawer; a. Check MAR/TAR for order. b. Note any allergies or contraindications the resident may have prior to drug administration....J. After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR or TAR, and controlled substance sign out record...M. When | | | |

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| | administering an "as needed" (PRN) medication, document reason for giving, observe for medication actions/reactions and record [on the PRN effectiveness section/nurse's notes]...." 4. The clinical record for Resident B was reviewes on 6/5/2019 at 11:00 a.m. The diagnosis for Resident B included, but were not limited to, right ankle fracture.<br><br>During an interview on 6/5/2019 at 11:00 a.m., Resident B indicated she waited a long time to receive her pain medications after she requested them, making it hard for her to get her pain under control.<br><br>The clinical record contained a physician's order indicating Resident B was to receive Oyxcodone-Acetaminophen ( narcotic pain medication) 10-325 mg (milligrams) every 6 hours as needed for pain.<br><br>The MAR (Medication Administration Record) for June 2019 was reviewed. It indicated that Resident B had received oxycodone-acetaminophen at the following time:<br><br>6/1/2019 at 10:15 a.m. for a pain level of 5, 6/2/2019 at 3:03 p.m. for a pain level of 5,<br>6/3/2019 at 1:57 a.m. for a pain level of 6 and 11:01 a.m. for a pain level of 4<br>6/6/2019 at 12:01 a.m. for a pain level of 6 and 11:40 p.m. for a pain level of 4,<br>6/7/2019 at 8:85 a.m. for a pain level of 3.<br><br>On 6/11/2019 at 8:50 a.m., the Director of Nursing Services provided the narcotic sign out record for Resident B's oxycodone- acetaminophen. It indicated that Resident B had received oxycodone- acetaminophen at the following times: | | | |

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|---|---|---|---|
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|---|---|---|---|---|
| | 6/1/2019 at 9:00 am, 4:00 p.m., and 10:00 p.m.,<br>6/2/2019 at 9:00 a.m., 3:00 p.m., and 9:00 p.m.,<br>6/3/2019 at 2:00 a.m, 11:01 a.m., 5:00 p.m., and 9:00 p.m.,<br>6/4/2019 at 3:40 a.m., 9:40 a.m., 3:40 p.m., ad 9:30 p.m.,<br>6/5/2019 at 1:30 a.m., 9:00 a.m., and 4:00 p.m.,<br>6/6/2019 at 12:00 a.m., 8:00 a.m., 5:00 p.m., and 11:00 p.m.,<br>6/7/2019 9:00 a.m.<br><br>An interview was conducted with the Director of Nursing Services (DNS) on 6/10/19 at 4:32 p.m. She indicated that narcotic medications should be documented as administered on the MAR and the narcotic sign out record. The residents' pain level should be evaluated and effectiveness after administration of PRN medication.<br><br>5. The clinical record for Resident R was reviewed on 6/5/2019 at 2:48 p.m. The diagnosis for Resident R included, but were not limited to, right hip fracture.<br><br>During an interview on 6/5/2019 at 2:50 p.m., Resident R indicated she had to wait a long time for her pain medication to be administered after she asked for them.<br><br>The clinical record contained a physician's order indicating Resident R was to receive Oyxcodone HCL( narcotic pain medication) 15 mg (milligrams) every 4 hours as needed for moderate pain.<br><br>The MAR (Medication Administration Record) for June 2019 was reviewed. It indicated that Resident R had received oxycodone-acetaminophen at the following time:<br><br>6/3/2019 at 3:55 a.m. for a pain level of 3, | | | |

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|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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|---|---|---|---|---|
| | 6/4/2019 at 9:15 a.m. for a pain level of 5,<br>6/7/2019 at 11:35 a.m. for a pain level of 4 and 6:28 p.m. for a pain level of 4<br>6/9/2019 at 12:20 a.m. for a pain level of 5 and 8:33 a.m. for a pain level of 5.<br><br>On 6/11/2019 at 8:50 a.m., the Director of Nursing Services provided the narcotic sign out record for Resident R's oxycodone HCL. It indicated that Resident R had received oxycodone-acetaminophen at the following times:<br><br>6/1/2019 at 6:00 a.m. and 9:00 p.m.,<br>6/2/2019 at 9:15 a.m. and 9:00 p.m.,<br>6/3/2019 at 3:00 a.m. and 5:00 p.m.,<br>6/4/2019 at 5:30 a.m. and 9:00 p.m.,<br>6/5/2019 at 12:00 a.m. and 4:00 p.m.,<br>6/6/2019 at 9:00 p.m.,<br>6/7/2019 at 11:30 a.m. and 6:30 p.m.,<br>6/8/2019 at 5:30 a.m.,<br>6/9/2019 at 12:00 a.m. and 8:33 a.m.<br><br>An interview was conducted with the Director of Nursing Services (DNS) on 6/10/19 at 4:32 p.m. She indicated that narcotic medications should be documented as administered on the MAR and the narcotic sign out record. The residents' pain level should be evaluated and effectiveness after administration of PRN medication.<br><br>On 6/11/2019 at 10:44 a.m., the Nurse Consultant provided the PRN (as needed) Medication Administration Documentation Protocol which reads as follows: " PRN Medications is to be documented at the time of administration. The nurse... will document the administration of the medication in the eMAR.... A follow up progress not will be required for all PRN medications that will include the effectiveness of the PRN medications...." | | | |

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|---|---|---|---|
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| | This Federal Tag relates to Complaint #IN00297610.<br><br>3.1-37(a) | | | |
| F 0761 SS=D Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>Based on observation, interview and record review the facility failed to ensure medications were labeled with an open/ expiration date for 1 of 2 medication rooms observed. (Resident D) | F 0761 | The facility will ensure this requirement is met through the following actions:<br><br>1. Residents D was not harmed | 07/08/2019 |

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|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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|---|---|---|---|---|
| | Findings include:<br><br>The clinical record for Resident D was reviewed on 6/10/2019 at 11:37 a.m. The diagnosis for Resident D included, but were not limited to, diabetes.<br><br>The medication room for Unit 2 was observed with UM (Unit Manager) 2 on 6/10/2019 at 11:15 a.m. The refrigerator in the medication room contained a vial of Novolog, labeled with Resident D's name and a delivery date of 12/ 20/2018. The Novolog vial was open. It was not labeled with a date which it was opened.<br><br>During an interview on 6/11/2019 at 11:20 a.m., UM 2 indicated the Novolog vial should be labeled with the open date.<br><br>On 6/11/2019 at 10:44 a.m., the Nurse Consultant provided a policy labeled "Medication Storage in the Facility" which was revised August 2014. The policy read as follows: "Policy: Medications and Biological's are stored safely, securely and properly, following manufacturer's recommendations...Expiration Dating [Beyond-use-dating]...D. When the original seal of a manufacture's container or vial is initially broken, the container or vial will be dated. 1) the nurse shall place 'date opened' sticker on the medication and enter the date opened and the new date of expiration...The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/ guidelines require different dating..."<br><br>3.1-25(j) | | by the alleged deficient practice. The vial of Novolog was discarded and dated and labeled vial was on the medication cart.<br><br>2. All residents who receive insulin have the potential to be affected. For staff education, see below. For those residents receiving insulin, all insulin was audited to ensure any opened vial was labeled and dated.<br><br>3. The Guidelines for the Storing of Medications was reviewed, and no changes were indicated at this time. Licensed nursing staff and QMA's will be educated on this policy.<br><br>To ensure compliance DON/Designee will audit medication carts twice weekly to ensure no open undated insulins are stored in the medication cart and or medication room. These audits will continue for 8 weeks and until 4 consecutive weeks of 100%compliance are achieved. Then, they will be completed 4 times a month for 3 months and until 2 consecutive months of 100 % compliance is achieved. Any findings will be discussed, logged and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
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| F 0770 SS=D Bldg. 00 | 483.50(a)(1)(i)<br>Laboratory Services<br>§483.50(a) Laboratory Services.<br>§483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br>(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.<br>Based on interview and record review, the facility failed to obtain a lab as ordered for 1 of 6 residents reviewed for unnecessary medications. (Resident E)<br><br>Findings include:<br><br>The clinical record for Resident E was reviewed on 6/10/19 at 9:37 a.m. The diagnoses for Resident E included, but was not limited to long term use of anticoagulants.<br><br>A physician order dated 4/5/19 indicated Prothrombin Time and International Normalized Ration (PT/INR) lab was to be obtained for Resident E every Monday and Thursday due to anticoagulant medication.<br><br>A physician order dated 5/21/19 indicated staff was to give 3 milligrams of coumadin to Resident E daily.<br><br>The clinical record did not include a lab for Thursday, May 27, 2019.<br><br>An interview was conducted with the Director of Nursing Services on 6/11/19 at 8:43 a.m. She indicated the 5/27/19 lab was missed in error. | F 0770 | The facility will ensure this requirement is met through the following actions:<br><br>1. Resident E had no negative effects related to the alleged deficient practice. Resident's physician and responsible made aware.<br><br>2. All residents requiring a routine blood draw that falls on a holiday have the potential to be affected. All residents were reviewed who have routine blood draws scheduled. A physician order will be obtained to schedule the routine lab to the day before or the day after the holiday for any resident who has a routine blood draw scheduled on a holiday.<br><br>3. Nursing staff educated facility protocol and expectations on scheduling routine blood draws.<br><br>4. To ensure compliance, the DON/Designee will audit of 5 | 07/08/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
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| | A "Following Medication-Physician orders/Parameters policy was provided by the Nurse Consultant on 6/11/19 at 10:44 a.m. It indicated "Purpose: To administer medication in a safe and effective manner and following physician order parameters.."<br><br>This Federal Tag relates to Complaint #IN00297610.<br><br>3.1-49(a) | | residents weekly who have routine blood draw for 8 weeks until 100% compliance is achieved, then 5 per month for 3 months and until 2 consecutive months of 100% compliance is achieved. Any finding will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |
| F 0814 SS=F Bldg. 00 | 483.60(i)(4)<br>Dispose Garbage and Refuse Properly<br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br>Based on observation, interview, and record review, the facility failed to ensure dumpster lids and doors were maintained closed. This had a potential to affect 105 residents that reside in the facility.<br><br>Findings include:<br><br>An observation was made of the dumpster on 6/6/19 at 1:32 p.m. The top left lid was observed opened.<br><br>During a kitchen tour on 6/10/19 at 10:19 a.m., an observation was made of the dumpster. The left side door was open an white trash bags and card board boxes were observed in the dumpster. One trash bag in the dumpster was observed opened with white food debree spilling out of it. There was a sign on the dumpster doors that indicated "Keep dumpster lids and doors closed".<br><br>An observation was made of the dumpster with | F 0814 | The facility will ensure this requirement is met through the following actions:<br><br>1. No residents were affected by the alleged deficient practice.<br><br>2. All residents have the potential to be affected by the alleged deficient practice<br><br>3. Staff educated on Use of Outside Waste Disposal Dumpster policy.<br><br>4. To ensure compliance, the Executive Director /Designee will monitor the dumpster lids and surrounding area 5 times weekly for 4 weeks, then 2 times a week for 4 weeks, then monthly until 100% compliance is achieved for | 07/08/2019 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
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| | the Director of Dining Services on 6/10/19 at 12:10 p.m. The left side door was observed opened. White trash bags were observed in the dumpster with cardboard boxes. The door to the dumpster had a sign that indicated "Keep dumpster lids and doors closed".<br><br>An interview was conducted with the Director of Dietary Services on 6/10/19 at 12:13 p.m. She indicated the top lids and doors to the dumpster were to remain closed.<br><br>A dumpster policy was provided by the Nurse Consultant on 6/11/19 at 10:44 a.m. It indicated "..Policy.. Items to be discarded, including food waste garbage, trash and delivery packaging, will be disposed of, as needed throughout the day and at the end of each day. Such items will be held for pick up in covered dumpsters in good repair provided via contact service with disposal company...Procedure...4. Containers will be emptied as often as necessary throughout the day and at the end of each day. Trash bags shall be sealed prior to removing them from the facility. Trash will be deposited into a sealed container, (referred to as "dumpster"), outside the premises. 5. A contract will be maintained with a waste disposal company for purposes of providing and emptying the dumpster. Such dumpster will be in good condition with a securely fitting lid. The dumpster will be emptied frequently enough to avoid overflowing trash..."<br><br>3.1-21(i)(5) | | two consecutive months. Any finding will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |
| F 0842 SS=D Bldg. 00 | 483.20(f)(5); 483.70(i)(1)-(5)<br>Resident Records - Identifiable Information<br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

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| | (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records,<br>regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard | | | |

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| | medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>Based on interview and record review the facility failed to maintain accurate and complete records for 1 of 6 residents reviewed for unnecessary medications. (Resident F)<br><br>Findings include:<br><br>The clinical record for Resident F was reviewed on 6/10/19 at 9:00 a.m. The diagnoses for Resident F included, but was not limited to end stage kidney disease.<br><br>A physician order dated 11/19/18 indicated Resident F was to be picked up at 6:20 a.m., on Tuesdays, Thursdays, Saturdays for dialysis. | F 0842 | The facility will ensure this requirement is met through the following actions:<br><br>1. The medication times were changed on Resident F's medications on dialysis days.<br><br>2. All residents who receive dialysis have the potential to be affected by the alleged deficient practice. An audit of all residents receiving dialysis performed to ensure proper medication administration times. | 07/08/2019 |

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|---|---|---|---|
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|---|---|---|---|---|
| | A physician order dated 5/2/19 indicated Resident F was to receive 1.25 milligrams of zyprexa twice a day.<br><br>A physician order dated 5/3/19 indicated Resident F was to receive 5 milligrams of midodrine once a day on Tuesdays, Thursdays, and Saturdays.<br><br>The May 2019 Medication Administration Record for Resident F indicated the following:<br><br>scheduled 9:00 a.m. midodrine:<br>5/4/19 - documented as not administered due to Resident F not in building,<br>5/9/19 - documented as not administered due to Resident F not in building,<br>5/14/19 - documented as not administered due to Resident F not in building,<br>5/16/19 - documented as not administered due to Resident F not in building,<br>5/18/19 - documented as not administered due to Resident F not in building,<br>5/21/19 - documented as not administered due to Resident F not in building,<br>5/23/19 - documented as not administered due to Resident F not in building,<br>5/28/19 - documented as not administered due to Resident F not in building,<br>5/30/19 - documented as not administered due to Resident F not in building,<br><br>scheduled 9:00 a.m. zyprexa:<br>5/4/19 - documented as not administered due to Resident F not in building,<br>5/9/19 - documented as not administered due to Resident F not in building,<br>5/14/19 - documented as not administered due to Resident F not in building,<br>5/16/19 - documented as not administered due to | | 3. Licensed Nursing staff educated on scheduling of dialysis medication times<br><br>4. To ensure compliance, DNS/Designee will audit dialysis medication administration 3 times weekly for 3 weeks, 2 times weekly for 3 weeks, then weekly for 3 weeks, then monthly until 100% compliance is noted for 3 consecutive months. Any finding will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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|---|---|---|---|---|
| | Resident F not in building,<br>5/18/19 - documented as not administered due to Resident F not in building,<br>5/21/19 - documented as not administered due to Resident F not in building,<br>5/23/19 - documented as not administered due to Resident F not in building,<br>5/28/19 - documented as not administered due to Resident F not in building,<br>5/30/19 - documented as not administered due to Resident F not in building,<br><br>The June 2019 Medication Administration Record indicated the following:<br><br>scheduled 9:00 a.m. midodrine:<br>6/1/19 - documented as not administered due to Resident F not in building,<br>6/4/19 - documented as not administered due to Resident F not in building,<br>6/6/19 - documented as not administered due to Resident F not in building,<br><br>scheduled 9:00 a.m. zyprexa:<br>6/1/19 - documented as not administered due to Resident F not in building,<br>6/4/19 - documented as not administered due to Resident F not in building,<br>6/6/19 - documented as not administered due to Resident F not in building,<br><br>There was no documentation in Resident F's record that Resident F had received the 9:00 a.m., midodrine or zyprexa medications on those days.<br><br>An interview was conducted with the Director of Nursing Services (DNS) and License Practical Nurse (LPN) 4 on 6/7/19 at 3:57 p.m. The DNS indicated the staff was administrating the 9:00 a.m., midodrine and zyprexa to Resident F prior to | | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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|---|---|---|---|---|
| | her leaving to dialysis. Resident F was picked up at 6:30 a.m., so the night shift staff was administrating the medications not day shift. The staff was unable to document in the electronic medication record they had administered the midodrine and zyprexa due to the administration was too early. The record would not allow them. The night shift staff should have placed a progress note documenting they had administered the medications, or the scheduled time should have been changed to earlier. LPN 4 indicated she was documenting Resident F was not in the building to administer the medications, because she was not going to document she had administered the 9:00 a.m., midodrine and zyprexa since she had not. The DNS indicated she would changed the scheduled time to administer the midodrine and zyprexa in the electronic medication record for an earlier time. The night shift staff would then be able to continue to administer, and document on the electronic medication record they had administered.<br><br>The medical records policy was provided by the Nurse Consultant on 6/11/19 at 10:44 a.m. It indicated "...Purpose: ..To define what is to be contained in a clinical record and when a record may be released...Policy: It is the policy of this facility to retain, store, and destroy medical records in accordance with the Federal guidelines....Procedure: 1. Medical Records must be: Complete. Accurately documented. Readily accessible. Systematically organized..."<br><br>This Federal Tag relates to Complaint #IN00297610.<br><br>3.1-50(a) | | | |

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| F 0880 SS=E Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; | | | |

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|---|---|---|---|---|
| | (iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, interview, and record review, the facility used a cleaner not deemed for healthcare settings on resident's bed side table, failed to ensure proper hand hygiene and glove use when transporting dirty laundry, during resident care, and prior to administering an injection for 1 of 5 residents reviewed for medication administration, 1 of 2 residents | F 0880 | The facility will ensure this requirement is met through the following actions:<br><br>1. The facility is no longer using the chemical cited.<br><br>2. All residents have the potential | 07/08/2019 |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| | reviewed for skin conditions, 77 of 105 residents having their laundry done at the facility, and 1 of 1 resident randomly observed for room cleaning. (Residents L, M, and Z)<br><br>Findings include:<br><br>1. An observation, on 6/10/19 at 3:04 p.m., was made of housekeeper 7 picking up dirty linen from each unit's dirty linen closet. Housekeeper 7 donned clean gloves prior to wheeling a blue bin down the hall and would stop at each dirty linen closet, place the bagged dirty linen in the blue bin, remove his dirty gloves, place the dirty gloves in the blue bin, cover the bin and then donned a clean pair of gloves before he went to the next dirty linen closet.<br><br>An interview on the same day at 3:22 p.m. with the Environmental Services Director (ESD) indicated that hand hygiene should have been performed after the removal of dirty gloves and prior to donning clean gloves.<br><br>A Handwashing policy received on 6/10/19 at 8:46 a.m. from the Director of Nursing Services states, "....when you may use Alcohol based hand rub...after removing gloves..."<br><br>A Resident Care Procedure #04- Gloves received on 6/11/19 from Nurse Consultant states, " 1. wash hands, 2. ...slide one glove on...3. ...slide opposite hand in the second glove...12. ...dispose of gloves with touching outside of gloves and contaminating hands. 13. wash hands."<br><br>2. A random observation of Housekeeper 1 was made on 6/10/19 at 2:52 p.m. while she was cleaning resident M's room. Housekeeper 1 sprayed a cleaning liquid onto resident M's | | to be affected by the alleged deficient practices. All chemicals in use at the time of exit are appropriate for use.<br><br>3. Nursing staff educated on Hand washing policy and glove policy and handling of soiled linen and housekeeping staff were educated on appropriate chemical usage..<br><br>4. To ensure compliance, DNS/Designee will conduct random medication pass, hand washing and gloves use 5 times weekly for 2 weeks, 2 times weekly for 4 weeks, then weekly for 4 weeks, then monthly until 100% compliance is noted for 3 consecutive months. The Executive Director or his designee will audit chemicals in use weekly for 4 weeks then monthly for 2 months and until 100% compliance continues. Any finding will be discussed, logged, and tracked at the facility's monthly QAPI meetings. Frequency and duration of the reviews will be adjusted as needed. . | |

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|---|---|---|---|---|
| | bedside table and immediately wiped it off. The label of the cleaner read, "Consume eco-lyzer-all purpose cleaner...do not use this product on food contact surfaces in preparation, or storage areas to eliminate possible food contamination and spillage...do not use in patient healthcare areas."<br><br>An interview on 6/10/19 at 3:02 p.m.with EDS indicated, the cleaner used for the bed side tables was Consume Eco-lyzer.<br><br>A copy of the label from the Consume Eco-lyzer bottle was received on the same day from ESD at 3:14 p.m.. It states, "...Note: Consume Eco-lyzer contains viable bacterial cultures. Do not use this product on food contact surfaces in preparation or storage areas to eliminate possible food contamination and spoilage. The bacteria in this product may cause infection if introduced into an open wound in sufficient quantity. Do not use in patient healthcare areas...is effective against the following pathogenic and odor causing bacteria...Proteus vulgaris (a bacteria), Pseudomonas ptefaciens ( a bacteria), Serratia odorfera (a bacteria), Staphylocuccus aureus (a bacteria) and Salmonella enterica (a bacteria)...HIV-1 (AIDS a virus), Herpes simplex Virus Type 1 (a virus) and Influenza A2 (a virus)...Thoroughly saturate surfaces for 10 minutes using a cloth, mop, sponge or coarse foamer. For virucidal (virus killing) activity, a 5 minute contact is adequate. Rinse with water or allow to air dry..."<br><br>An interview with Assistant Director of Nursing Service (ADNS), on the same day, at 3:51 p.m. indicated, she was unaware the product being used to clean the bedside table in resident M's room stated, on the label, it was not to be used in healthcare areas and was going to follow up with | | | |

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|---|---|---|---|
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|---|---|---|---|---|
| | DNS (Director of Nursing Service) and the ED (Executive Director) concerning this issue.<br><br>On 6/11/19 at 10:54 a.m., an interview with the ED indicated, he was unaware the incorrect product was being used to clean resident M's room. He indicated the Eco-lyzer was intended to be used specifically for the floor in another resident's room to control odor and should not have been used in any other resident rooms. The ED stated he conducted an in-service with the housekeeping staff on 6/10/19. A copy of the in-service sign sheet was provided at the same time as the conversation. The in-service sign sheet stated, "Effective IMMEDIATELY (sic) cleaning products to be used:<br>(NON- ISOLATION) Oxivir Five 16 OR Crew Floor & Surface Disinfectant Cleaner<br>(ISOLATION) CLOROX HEALTHCARE BLEACH GERMICIDAL IN QUART BOTTLE (sic)<br><br>The Environmental Daily Cleaning check off sheet was received from Nurse Consultant on 6/11/19 at 12:54 p.m. states, "....5. Dust/Wipe down:...d. Wipe off phone, call light cords and button, all door knobs, TV remote control, and wipe off Overbed (sic) table top with "sanitizer" (sic)..."3. The clinical record for Resident L was reviewed on 6/7/2019 at 2:00 p.m. The diagnosis for Resident L included, but were not limited to, diabetes.<br><br>On 6/7/2019 at 11:56 a.m., LPN (Licensed Practical Nurse) 5 was observed administering medications to Resident L. LPN 5 went to the medication cart to obtain Humalog (insulin) to administer to Resident L. She was unable to locate the medication in the medication cart. She locked the cart and went to the emergency drug supply room. She opened the door to the emergency drug room with her bare hands. She then went to the | | | |

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| | refrigerator in the emergency drug room and opened it with her bare hands, removed the emergency insulin kit and obtained Humalog. She then went back to the medication cart and obtained a needle and alcohol swab from the cart and then locked the medication cart with her bare hands. LPN 5 entered Resident L's room and obtained a pair of disposable gloves. She put on the disposable gloves and administered the medication. She did not perform hand hygiene before putting on the disposable gloves.<br><br>During an interview on 6/7/2019 at 12:15 p.m., LPN 5 indicated she should have done hand hygiene prior to putting on the disposable gloves and administering the Humalog.<br><br>On 6/10/2019 at 8:46 a.m., the Director of Nursing Services provided the Resident Care Procedure #04- Gloves, which was revised April 2017. The Procedure reads as follows: "Procedure Steps. 1. Wash hands 2. If right- handed, slide one glove on left hand [reverse, if left- handed]..."4. The clinical record for Resident Z was reviewed on 6/5/19 at 10:52 a.m. The diagnoses for Resident Z included, but were not limited to, heart failure, chronic obstructive pulmonary disease, major depressive disorder, and anxiety.<br><br>An observation of Resident Z's right ear was made on 6/4/19 at 2:32 p.m. during a Resident Council meeting. There was an open area in the middle of her outer ear, with redness. There was no dressing on her ear.<br><br>An observation of Resident Z's right ear was made on 6/5/19 at 9:34 a.m. in her room. Resident Z was dressed and in her wheel chair. The open area on her ear was red and bloody with a small piece of toilet paper stuck to the area. Blood had | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155628 | A. BUILDING 00<br>B. WING | 06/11/2019 |

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

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| | seeped through the toilet paper.<br><br>An interview was conducted with Resident Z on 6/5/19 at 9:34 a.m. She indicated she put toilet paper on her ear, because it was bleeding and had been bleeding since the previous day.<br><br>On 6/5/19 at 10:12 a.m., an observation of Resident Z's right ear was made with LPN 10 in Resident Z's room. LPN 10 donned gloves, then threw them away, did not perform hand hygiene, grabbed a wet wipe with her bare hand, and proceeded to wipe Resident Z's ear with no gloves on. Resident Z's ear had a red scab with dried blood around it. LPN 10 then donned another pair of gloves, grabbed another wipe, and wiped Resident Z's right ear with the wipe. She did not perform hand hygiene prior to donning the second pair of gloves.<br><br>The Hand Washing policy was provided by the DNS (Director of Nursing Services) on 6/10/19 at 8:46 a.m. It read, "When you may use Alcohol Based Hand Rub: ...Before direct patient contact...After removing gloves...After contact with blood, body fluids, mucus membranes, non-intact skin, and wound dressings IF hands are NOT visibly soiled."<br><br>The Resident Care Procedure #04 Gloves was provided by the DNS on 6/10/19 at 8:46 a.m. The first and last steps were to wash hands.<br><br>3.1-18 (l) | | | |