STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	01/11/2022

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00370096. Complaint IN00370096 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684, F686 and F690. Survey dates: January 10 and 11, 2022 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Census Bed Type: SNF/NF: 105 Total: 105 Census Payor Type: Medicare: 10 Medicaid: 80 Other: 15 Total: 105 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 14, 2022	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care 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			

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

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure treatments to the residents' skin conditions were provided for 2 of 4 residents reviewed for skin conditions. (Resident B and D) Findings include: The clinical record for Resident B was reviewed on 1/10/22 at 1:00 p.m. The diagnosis included, but was not limited to: neuromuscular bladder and muscle weakness. A physician order dated 12/25/21 indicated Resident B's treatment to her moisture associated skin damage (MASD)on her sacrum was to "cleanse area with normal saline or wound cleanser. Pat dry. Apply zinc oxide to periwound. Lightly pack wound with anasept and calcium alginate. Cover with foam dressing every day shift for wound care." The December 2021 Treatment Administration Record indicated Resident B's treatment on her sacrum had not been documented as provided on 12/26/21. During a confidential interview on 1/11/22, Resident B had a wound on her sacrum that had gotten worse due to lack of care. An interview was conducted with the Director of Nursing on 1/11/22 at 2:20 p.m. She indicated she was unable to provide documentation Resident B's treatment to her sacrum was provided on 12/26/21.	F 0684	The facility will ensure this requirement is met through the following corrective measures: 1. Resident B and D are receiving treatments as prescribed per MD orders. 2. All other residents have the potential to be affected. See below for corrective measures moving forward. 3. The administration/treatment policy and physician order policy were reviewed; no changes are indicated. Nursing staff education initiated on the importance of following and signing off medication/treatment administrations. A performance improvement tool has been initiated. The DON/designee will review ETAR (3) times weekly for 6 weeks and until 100% compliance is attained, then weekly for two (2) months and monthly for three (3) months until 100% compliance is maintained. 4. The findings of reviews will be presented during the facility's QAPI meetings, and the plan of action adjusted accordingly.	01/28/2022

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	2. The clinical record for Resident D was reviewed on 1/11/22 at 8:40 a.m. The diagnosis included, but was not limited to: colostomy, artificial opening of urinary tract, and paraplegia. A Quarterly Minimum Data Set (MDS) dated 12/31/21, indicated Resident D was cognitively intact. A care plan last review date on 12/22/21 indicated "I am at risk for developing pressure ulcers related to incontinence one or more diagnosis that put me at a higher risk...Interventions...You will assist me in turning and repositioning at least every two hours and more frequently as needed. You will give incontinence care to me and apply barrier cream as needed. A physician order dated 10/16/21 indicated "triad hydrophilic wound dress paste (wound dressings) Apply to sacrum/coccyx/buttocks topically every day shift for prevention." A physician order dated 4/22/21 indicated "may use house barrier cream to buttocks and scrotum every shift and as needed." A physician order dated 4/9/21 indicated "Change colostomy bag in the evening every Fri [Friday]. A weekly skin observation assessment dated 1/7/22 indicated Resident D's skin had open areas. There was no documented location of the open areas. During an interview with Resident D on 1/11/22 at 12:27 p.m., he indicated he has a wound on his bottom the staff are not consistent with providing			

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	the treatment. At that time, the resident was observed lying in his bed with a gown on. The staff should be applying an ointment, and a dressing once a day. It has not been done in 2-3 days. An observation was made of Resident D in his bed with Qualified Medication Aide (QMA) 2 on 1/11/22 at 12:35 p.m. QMA 2 was observed turning the resident to observe his back side. Resident D had been lying on a square shaped incontinent pad. The incontinent pad was soiled with a brown-black substance from width to width of the pad in a large circled shape that had an odor. A foam dressing undated was observed on the resident's lower back. QMA 2 at that time indicated she was unaware of any dressings needed for Resident D. She was unsure why a foam dressing was on the resident. She had not provided any treatments to the resident that day. QMA 2 placed the resident back on the soiled incontinent pad and indicated she would notify the nurse. An observation was made of Resident D in bed with Registered Nurse (RN) 1, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 1/11/22 at 1:10 p.m. RN 1 indicated she had not provided any treatments to the resident that day. Resident D was turned on his side. The resident was lying on a soiled incontinent pad that contained a brown-black substance. The undated foam dressing located on his lower back was removed. The resident's scrotum was observed to be excoriated and bleeding. RN 1 washed the resident's skin, and applied skin protectant and triad paste to the resident's scrotum, coccyx, and buttocks. An interview was conducted with the Director of			

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	Nursing on 1/11/22 and 2:10 p.m. She indicated the soilage on Resident D's incontinent pad could have been stool from his rectum. A wound policy was provided by the Nurse Consultant on 1/11/22 at 8:47 a.m. It indicated, "...22. Physician ordered treatments will be documented on the TAR after each administration..." This Federal Tag relates to complaint IN00370096. 3.1-37			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to provide treatment to a resident's pressure ulcer, as ordered, for 1 of 4 residents reviewed for pressure ulcers and skin conditions. (Resident F) Findings include: The clinical record for Resident F was reviewed on	F 0686	The facility will ensure this requirement is met through the following corrective measures: 1. Resident F is receiving treatments as prescribed per MD orders. 2. All other residents have the potential to be affected. See	01/28/2022

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	1/10/22 at 2:07 p.m. The diagnoses included, but were not limited to, dementia and unstageable pressure ulcer to right scapula. She was admitted to the facility on 12/30/21. The 1/4/22 pressure ulcer care plan indicated she was admitted with an unstageable pressure ulcer to her right scapula. An intervention was for her to receive her treatment as ordered. The 12/30/21 Initial Pressure Ulcer Report, completed by LPN (Licensed Practical Nurse) 4, indicated she was admitted with a pressure ulcer that measured 3.5 cm x 1.0 cm (centimeters.) It read, "Wound is located on back of neck. No drainage. No odor. Periwound intact. Appears to be a blister/scar that has scabbed over at this time." The physician, family, and dietary were all notified of the pressure ulcer on 12/30/21. The initial treatment was to cleanse with normal saline, pat dry, and apply dry dressing. The physician's orders read, "Pressure injury: back of neck: Cleanse with NS [normal saline,] pat dry, apply calcium alginate and foam dressing every day shift for wound care," from 12/31/21 to 1/4/22. The December, 2021 and January, 2022 TARs (treatment administration records) indicated the treatment order to the back of neck was not completed on 12/31/21, 1/1/22, 1/2/22, or 1/3/22. The TARs did not indicate refusal, sleeping, a leave of absence, hospitalization, or other reason for not completing the treatment on these days. The TARs did not indicate daily observation of the wound on these days. The progress notes did not reference completion of the treatment or daily observation of the wound		below for corrective measures moving forward. 3. The medication administration/treatment policy and physician order policies were reviewed; no changes are indicated. Nursing staff education initiated on the importance of following and signing off medication/treatment administrations. A performance improvement tool has been initiated. The DON/designee will review ETAR (3) times weekly for 6 weeks and until 100% compliance is attained, then weekly for two (2) months and monthly for three (3) months until 100% compliance is maintained. 4. The findings of the reviews will be presented during the facility's QAPI meetings and the plan of action adjusted accordingly.	

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	from 12/31/22 through 1/3/22. The 1/4/22 Skin & Wound Evaluation, completed by the Wound Nurse, indicated an unstageable pressure ulcer to her right scapula that was present on admission. It measured 2.4 cm x 2 cm, covering an area of 3.1 square cm. with a moderate amount of serosanguineous exudate. The physicians orders changed on 1/4/22 to "Pressure Injury: R [right] scapula: Cleanse with normal saline or wound cleanser. Pat dry. Apply skin prep to periwound. Apply medihoney et [and] calcium alginate to wound bed only. Cover with foam dressing every day shift for wound care, starting 1/5/22." The January, 2022 TAR indicated treatment was completed daily beginning 1/4/22. An interview was conducted with the Wound Nurse on 1/10/22 at 3:20 p.m. She indicated the orders for the back of the neck and right scapula were referencing the same area. She didn't see the area until pictures were obtained on 1/4/22 after LPN 4 informed her of the drainage coming from the area. Since the MAR didn't indicate the treatment was completed from 12/31/21 through 1/3/22, there was no way to verify whether it was completed. After reviewing the pictures and speaking with the physician, they decided medihoney would be a better treatment, so it was changed to medihoney on 1/4/22. The Wound Assessment policy was provided by the Nurse Consultant on 1/11/22 at 8:47 p.m. It read, "22. Physician ordered treatments will be documented on the TAR after each administration. 23. A daily observation of the wound will be completed by a licensed nurse for			

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	any open wound or skin condition requiring a dressing change." This Federal tag relates to Complaint IN00370096. 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must			

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	ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review, the facility failed to ensure treatment was provided to residents' with catheters for 2 of 3 residents reviewed for catheters. (Residents B and D) Findings include: 1. The clinical record for Resident B was reviewed on 1/10/22 at 1:00 p.m. The diagnosis included, but was not limited to: neuromuscular bladder and muscle weakness. A care plan dated 10/11/21 indicated the resident had an indwelling catheter. A physician order dated 10/11/21 indicated catheter care was to be provided to Resident B's foley catheter every shift. The December 2021 Treatment Administration Record indicated on the evening of 12/19/21, catheter care was not documented as provided. An interview was conducted with the Director of Nursing on 1/11/22 at 2:20 p.m. She indicated she was unable to provide documentation Resident B was provided catheter care on 12/19/21. 2. The clinical record for Resident D was reviewed on 1/11/22 at 8:40 a.m. The diagnosis included, but was not limited to: colostomy, artificial opening of urinary tract, and paraplegia.	F 0690	The facility will ensure the requirement is met through the following correction measures: 1. Resident B and D are receiving treatments related to catheter care as prescribed per MD orders. 2. All other residents who have a catheter have the potential to be affected. See below for corrective measures moving forward. 3. The catheter care policy reviewed; no changes indicated. Nursing staff education initiated on the importance of following physician orders and signing off treatment administrations. A performance improvement tool has been initiated. The DON/designee will check 3 random residents with catheters to ensure necessary care has been performed and will review ETAR (3) times weekly for 6 weeks and until 100% compliance is attained, then weekly for two (2) months and monthly for three (3) months until 100% compliance is maintained. 4. The findings of reviews will be presented during the facility's QAPI meetings and the plan of action adjusted accordingly.	01/28/2022

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	A Quarterly Minimum Data Set (MDS) dated 12/31/21, indicated Resident D was cognitively intact. A care plan dated 12/22/21 indicated "I [Resident D] have a supra pubic catheter placed...Interventions...You will observe for changes in the color, consistency, and odor of urine, changes in mental status, changes in amount of urine produced, and pain in lower back or lower abdomen..." A physician order dated 9/3/21 indicated the staff was to cleanse the catheter with normal saline or wound cleanser. Then apply a split dressing and secure with tape on day shift and evening shift. The January 2022 Treatment Administration Record indicated Qualified Medication Aide (QMA) 2 had documented on 1/11/22, she had provided catheter care twice that day. An observation was made of Resident D on 1/11/22 at 12:27 p.m. The resident's catheter was observed with a white split dressing and a foam dressing placed on top of the artificial opening on his abdomen for the catheter with no date. The top of the catheter tubing was observed with a black dried substance speckled all over the silicon top portion of the catheter. The urine flowing down the tubing had a white thick substance in it, and the color of the urine in the collection bag was an orange-red color. An interview was conducted with Resident D on 1/11/12 at 12:28 p.m. He indicated the catheter should be cleaned, and the dressing that covers the hole on his abdomen replaced at least once a day. It does not get done. The catheter had not been cleaned nor the dressing replaced in 2-3			

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	days. The staff had been telling him his urine was red in color after they empty the bag. It has been like that for "awhile" and has not been addressed. An interview was conducted with QMA 2 on 1/11/22 at 12:35 p.m. She indicated she had not provided catheter care on Resident D that day as documented. It was not in her "scope of practice" to provide catheter care. Resident D had mentioned earlier his urine was red in color. She had not reported to the resident's nurse. An interview was conducted with Certified Nursing Assistant (CNA) 3 on 1/11/22 at 12:39 p.m. She indicated Resident D's urine does at times appear red in color, and then other days it was clear yellow appearance. It goes back and forth. An observation was made of Resident D with Registered Nurse (RN) 1 on 1/11/22 at 12:45 p.m. RN 1 was observed providing catheter care on the resident. RN 1 removed the undated dressing that was covering the artificial opening of the resident's catheter. The surrounding skin around the open area was observed with a brown-black substance. The catheter tubing had a dry black substance on the top portion of the tubing. RN 1 was observed using a white cloth and wound cleanser to wipe the surrounding skin. The brown substance was removed using the cloth. She then wiped the catheter tubing. RN 1 indicated at that time she had not provided catheter care that day. She was not aware the resident's urine had a white thick substance in it, and the color of his urine was orange-red. A catheter policy was provided by the Nurse Consultant on 1/11/22 at 8:47 a.m. It indicated "...Catheter Care...Policy:...Provide proper care			

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	while a resident is catheterized including observing for signs of catheter related infections..." This Federal Tag relates to complaint IN00370096. 3.1-41(a)(2)			