STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	10/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00183505. Complaint IN00183505 - Substantiated. Federal /State deficiencies related to the allegations are cited at F315, F514, and F9999. Survey dates: October 1 and 2, 2015 Facility number: 010478 Provider number: 155649 AIM number: 200197620 Census bed type: SNF/NF: 63 Total: 63 Census payor type: Medicare: 9 Medicaid: 41 Other: 13 Total: 63 Sample: 03 These deficiencies reflect State findings cited in accordance 410 IAC 16.2-3.1. QR completed by 14466 on October 09, 2015.	F 0000	Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law.	

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

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F 0315 SS=G Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure correct indwelling urinary catheter placement and assessment of urine return after catheter placement as indicated by facility policy and Lippincott professional standards for 1 of 2 residents reviewed for indwelling catheter care which resulted in traumatic indwelling catheter insertion and then removal with significant hemorrhage and sever pain. (Resident #A) Findings include:	F 0315	Resident A did not return to the facility after hospitalization. Other residents with catheters were not negatively affected by this practice. Nurses will be in-serviced and educated on the correct catheter care and insertion and removal of male/female catheters. All new licensed nurses will be oriented in orientation on facility's policies and procedures on Foley catheter insertions and successful return competence. A return demonstration on catheter care will be assessed for competency. When a catheter is inserted or changed the DON or	10/26/2015

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	Resident #A's clinical record was reviewed on 10/01/15 at 1:30 p.m. Diagnoses included, but were not limited to: diabetes, hypertension (above normal/high), chronic kidney disease, and coronary artery disease. A Brief Interview for Mental Status (BIMS) documented on 9/14/15, was scored as 14 out of 15 (cognitively intact). Physician orders dated 9/25/15 at 4:15 p.m., indicated Resident #A had an order for an indwelling urinary catheter, 16 french with 30 cc bulb (size of catheter), to be inserted prior to going for an MRI (magnetic resonance imaging), and to remove the indwelling catheter after Resident #A's MRI. The purpose of the indwelling catheter was to drain urine from the bladder as Resident #A would need to be supine (lie flat) for a longer period of time for the MRI. The clinical record lacked documentation the indwelling catheter had been placed and that Resident #A had left the facility for the MRI. Nursing notes dated 9/25/15 at 2:25 p.m., indicated an indwelling catheter was anchored prior to Resident #A leaving for the MRI earlier that day (time left not documented). There was no		designee will observe the procedure and monitor initial and follow up documentation for 90 days including all shifts and weekends (attachment A). The DON or designee will be completing the in-service by 10/26/15. The Quality Assurance Committee will review audit results monthly x 3 months. Then quarterly with a subsequent plan developed and implemented as necessary.	

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	documentation related to an assessment for the placement of the indwelling catheter. Interview with LPN #1 on 10/02/15 at 10:00 a.m. (nurse who placed and anchored the catheter on 9/25/15), indicated Resident #A was voiding urine while being cleansed for catheter placement. LPN #1 waited at few minutes for Resident #A to void. LPN #1 then re-cleansed Resident #A and inserted the catheter, without any concerns from the resident. LPN #1 indicated not having observed any urine return after catheter placement, but didn't think anything about this because Resident #A had just voided urine. LPN #1 had not charted how Resident #A tolerated the insertion procedure nor that there was no return of urine after the catheter insertion. LPN #1 had also not reassessed for any urine in the catheter drainage bag prior to Resident #A having left the facility to go to a local acute care hospital for the MRI. Nurses notes dated 9/25/15 at 3:00 p.m., indicated Resident #A had returned to the facility. Resident #A was noted to be bleeding around the tip of the penis, to be in pain, and areas on their underwear were noted to be blood stained. Urine output was approximately 100 cc of red			

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	liquid. The DON (Director of Nursing) was called into the room to assess. Resident #A was alert and oriented and indicated no concerns, just tired. Per physician order and resident and spouse request, the indwelling catheter was removed from Resident #A. Documentation indicated a 30 cc balloon was deflated and catheter tip was visualized and fell out without physical assistance. Blood was noted coming out of Resident #A's penis. Pressure was applied, the DON was notified, and vital signs taken were within normal limits. Nurses notes dated 9/25/15 at 6:30 p.m., indicated Resident #A requested to go to the bathroom and was noted to be chilling. Resident #A noted to have shortness of breath, respirations at 26, blood pressure at 186/60, Pulse 100, and oxygen saturations (SATs) were 63% (normal is 95 %) on room air. Resident #A was immediately placed on oxygen and oxygen SATs increased to 93%. Resident #A continued to have a towel over their groin and noted to have pink tinged urine. EMS (emergency medical service) was called and Resident #A was transported to a local acute care hospital.. Emergency room physician's notes dated 09/25/15 dictated at 7:30 p.m., indicated Resident #A was in the Emergency room			

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	(ER) with a diagnosis of hypoxia (lack of oxygen). ER notes did indicate chills without fever. ER physician indicated spouse indicated Resident #A was normal and awake today until he had an indwelling catheter that was placed then removed after an MRI today. Resident #A was admitted to critical care unit. Initial admission notes from the hospital attending physician dated 9/25/15, indicated chief complaint was penile pain and the patient (Resident #A); "had a fairly traumatic indwelling catheter insertion and then removal with significant hemorrhage [blood loss] and sever pain. Shortly thereafter the patient [Resident #A] developed hypotension [below normal blood pressure], bradycardia [slow heartbeat], hypoxemia [decreased arterial oxygen concentration] and severe alteration of mental status with near obtundation [less than full alertness]. ...he received aggressive IV [in the vein] fluid hydration. His blood pressure, mental status, and oxygenation have since improved quite well." Emergency room lab values dated 9/25/15, for hematocrit (percent of total blood volume) was 34.0% (normal range 42-52% per Mosby's diagnostic and laboratory test reference, ninth edition), and hemoglobin (red blood cells/oxygen			

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	carrying cells) was 11.6 GM/dl (normal range 14 -18 g/dl per Mosby's diagnostic and laboratory test reference). Review of the facility's policy related to indwelling catheter, received from the DON on 10/1/15 at 1:40 p.m., as current included, "...regular monitoring of urine quality and characteristics and monitor for catheter related complications." Lippincott nursing procedure book, 2009, indicated after insertion of an indwelling catheter, document the amount, color, and consistency of return urine and patient's tolerance to the procedure. Interview with the DON on 10/1/2015 and 10:00 a.m., indicated she had a 1:1 (one on one) inservice with LPN #1 and the Administrator indicated at the same time, she called LPN #1 and gave her a final written warning over the phone. This Federal tag relates to Complaint IN00183505. 3.1-41(a)(2)			

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F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure documentation was accurate and complete related to indwelling catheter insertion as indicated by facility policy and Lippincott professional standards for 1 of 2 residents reviewed with indwelling catheter care. (Resident #A) Findings include: Resident #A's clinical record was reviewed on 10/01/15 at 1:30 p.m. Diagnoses included, but were not limited to: diabetes, hypertension (above normal/high), chronic kidney disease, and coronary artery disease. A Brief Interview for Mental Status (BIMS) documented on 9/14/15, was scored as 14	F 0514	Resident A did not return to the facility after hospitalization. Other residents with catheters were not negatively affected by this practice. Nurses will be in-serviced and educated on the correct catheter care and insertion and removal of male/female catheters documentation The DON or designee will inservice the nurse staff by 10/26/15.. When a catheter is inserted or changed the DON or designee will monitor initial and follow up documentation for 90 days including all shifts and weekends (Attachment A). The Quality Assurance Committee will review audit results monthly x 3 months. Then quarterly with a subsequent plan developed and implemented as necessary	10/26/2015

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	out of 15 (cognitively intact). Physician orders dated 9/25/15 at 4:15 p.m., indicated Resident #A had an order for an indwelling urinary catheter, 16 french with 30 cc (ml) bulb (size), to be inserted prior to going for an MRI (magnetic resonance imaging), and to remove the indwelling catheter after Resident #A's MRI. The purpose of the indwelling catheter was to drain urine from the bladder as Resident #A would need to be supine (lie flat) for a longer period of time for the MRI. The clinical record lacked documentation the indwelling catheter had been placed and that Resident #A had left the facility for the MRI. Nursing notes dated 9/25/15 at 2:25 p.m., indicated an indwelling catheter was anchored prior to Resident #A leaving for the MRI earlier that day (time left not documented). There was no documentation related to an assessment for the placement of the indwelling catheter. Interview with LPN #1 on 10/02/15 at 10:00 a.m. (nurse who placed and anchored the catheter on 9/25/15), indicated Resident #A was voiding urine while being cleansed for catheter			

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	placement. LPN #1 waited at few minutes for Resident #A to void. LPN #1 then re-cleansed Resident #A and inserted the catheter, without any concerns from the resident. LPN #1 indicated not having observed any urine return after catheter placement, but didn't think anything about this because Resident #A had just voided urine. LPN #1 had not charted how Resident #A tolerated the insertion procedure nor that there was no return of urine after the catheter insertion. LPN #1 had also not reassessed for any urine in the catheter drainage bag prior to Resident #A having left the facility to go to a local acute care hospital for the MRI. Lippincott nursing procedure book, 2009, indicated after insertion of an indwelling catheter, document the amount, color, and consistency of return urine and patient's tolerance to the procedure. Interview with the DON (Director of Nursing) on 10/1/2015 and 10:00 a.m., indicated she had a 1:1 (one on one) inservice with LPN #1 and the Administrator indicated at the same time, she called LPN #1 and gave her a final written warning over the phone. This Federal tag relates to complaint IN00183505.			

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	3.1-50(a)(1) 3.1-50(a)(2)			
F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (g)The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the	F 9999	Resident A did not return to the facility after hospitalization. No others residents were negatively affected. The DON and Administrator will be educated on the Indiana State Department of Health Guidelines. The Administrator or designee will consult with the Director of Operations for all unusual occurrences.	10/26/2015

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	welfare, safety, or health of the resident or residents. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to notify the division of an unusual occurrence of a nurse having failed to implement indwelling catheter care as indicated by facility policy which resulted in traumatic indwelling catheter insertion and then removal with significant hemorrhage and sever pain for 1 of 1 reviews for unusual occurrences. (Resident #A). Findings include: Resident #A's clinical record was reviewed on 10/01/15 at 1:30 p.m. Diagnoses included, but were not limited to: diabetes, hypertension (above normal/high), chronic kidney disease, and coronary artery disease. A Brief Interview for Mental Status (BIMS) documented on 9/14/15, was scored as 14 out of 15 (cognitively intact). Physician orders dated 9/25/15 at 4:15 p.m., indicated Resident #A had an order for an indwelling urinary catheter, 16 french with 30 cc (ml) bulb (size), to be inserted prior to going for an MRI			

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	(magnetic resonance imaging), and to remove the indwelling catheter after Resident #A's MRI. The purpose of the indwelling catheter was to drain urine from the bladder as Resident #A would need to be supine (lie flat) for a longer period of time for the MRI. The clinical record lacked documentation the indwelling catheter had been placed and that Resident #A had left the facility for the MRI. Nursing notes dated 9/25/15 at 2:25 p.m., indicated an indwelling catheter was anchored prior to Resident #A leaving for the MRI earlier that day (time left not documented). There was no documentation related to an assessment for the placement of the indwelling catheter. Interview with LPN #1 on 10/02/15 at 10:00 a.m. (nurse who placed and anchored the catheter on 9/25/15), indicated Resident #A was voiding urine while being cleansed for catheter placement. LPN #1 waited at few minutes for Resident #A to void. LPN #1 then re-cleansed Resident #A and inserted the catheter, without any concerns from the resident. LPN #1 indicated not having observed any urine return after catheter placement, but didn't			

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	think anything about this because Resident #A had just voided urine. LPN #1 had not charted how Resident #A tolerated the insertion procedure nor that there was no return of urine after the catheter insertion. LPN #1 had also not reassessed for any urine in the catheter drainage bag prior to Resident #A having left the facility to go to a local acute care hospital for the MRI. Nurses notes dated 9/25/15 at 3:00 p.m., indicated Resident #A had returned to the facility. Resident #A was noted to be bleeding around the tip of the penis, to be in pain, and areas on their underwear were noted to be blood stained. Urine output was approximately 100 cc of red liquid. The DON (Director of Nursing) was called into the room to assess. Resident #A was alert and oriented and indicated no concerns, just tired. Per physician order and resident and spouse request, the indwelling catheter was removed from Resident #A. Documentation indicated a 30 cc balloon was deflated and catheter tip was visualized and fell out without physical assistance. Blood was noted coming out of Resident #A's penis. Pressure was applied, the DON was notified, and vital signs taken were within normal limits. Nurses notes dated 9/25/15 at 6:30 p.m.,			

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	indicated Resident #A requested to go to the bathroom and was noted to be chilling. Resident #A noted to have shortness of breath, respirations at 26, blood pressure at 186/60, Pulse 100, and oxygen saturations (SATs) were 63% (normal is 95 %) on room air. Resident #A was immediately placed on oxygen and oxygen SATs increased to 93%. Resident #A continued to have a towel over their groin and noted to have pink tinged urine. EMS (emergency medical service) was called and Resident #A was transported to a local acute care hospital.. Emergency room physician's notes dated 09/25/15 dictated at 7:30 p.m., indicated Resident #A was in the Emergency room (ER) with a diagnosis of hypoxia (lack of oxygen). ER notes did indicate chills without fever. ER physician indicated spouse indicated Resident #A was normal and awake today until he had an indwelling catheter that was placed then removed after an MRI today. Resident #A was admitted to critical care unit. Initial admission notes from the hospital attending physician dated 9/25/15, indicated chief complaint was penile pain and the patient (Resident #A); "had a fairly traumatic indwelling catheter insertion and then removal with significant hemorrhage [blood loss] and			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sever pain. Shortly thereafter the patient [Resident #A] developed hypotension [below normal blood pressure], bradycardia [slow heartbeat], hypoxemia [decreased arterial oxygen concentration] and severe alteration of mental status with near obtundation [less than full alertness]. ...he received aggressive IV [in the vein] fluid hydration. His blood pressure, mental status, and oxygenation have since improved quite well." Emergency room lab values dated 9/25/15, for hematocrit (percent of total blood volume) was 34.0% (normal range 42-52% per Mosby's diagnostic and laboratory test reference, ninth edition), and hemoglobin (red blood cells/oxygen carrying cells) was 11.6 GM/dl (normal range 14 -18 g/dl per Mosby's diagnostic and laboratory test reference). Review of the facility's policy related to indwelling catheter, received from the DON on 10/1/15 at 1:40 p.m., as current included, "...regular monitoring of urine quality and characteristics and monitor for catheter related complications." Per Lippincott nursing procedure book, 2009, indicated after insertion of a indwelling catheter, document the amount, color, and consistency of return urine and patient's tolerance to the procedure.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	10/02/2015

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	Interview with the DON on 10/1/2015 and 10:00 a.m., indicated she had a 1:1 (one on one) inservice with LPN #1 and the Administrator indicated at the same time, she called LPN #1 and gave her a final written warning over the phone. Interview with the Administrator on 10/02/15 at 11:30 a.m., indicated they did not feel said incident warranted a reportable as Resident #A did not leave in the condition he returned. On 10/02/2105 at 1:00 p.m., the DON (director of nursing) provided the abuse prevention, intervention, investigation and crime reporting policy, dated December 2012, to which the DON indicated this was the policy the facility follows. Review of the policy indicated, related to an unusual occurrence is an injury that was not observed by any person or the source of the injury could not be explained. This State tag relates to Complaint IN00183505.			

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