STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155664	A. BUILDING 00 B. WING	03/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE CREEK HEALTHCARE CENTER	4102 SHORE DR INDIANAPOLIS, IN 46254

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00288504. Complaint IN00288504 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684 and F692 . Survey date: March 5, 2019 Facility number: 010666 Provider number: 155664 AIM number: 200229930 Census Bed Type: SNF/NF: 80 Total: 80 Census Payor Type: Medicare: 6 Medicaid: 60 Other: 16 Total: 80 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on March 8, 2019.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint Survey on March 5, 2019. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial 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 interview and record review, the facility failed to provide nursing services, assessment, and intravenous fluids, for 1 of 3 residents reviewed for quality of care. (Resident B). Findings include: Record review was completed for Resident B on 3/5/19 at 9:49 a.m. The record indicated the resident's diagnoses include, but were not limited to, chronic obstructive pulmonary disease, chronic hepatitis, cirrhosis of liver, pain in unspecified joint, methicillin-resistant staphylococcus aureus (MRSA a bacterial infection resistant to many antibiotics), and elevated white blood count. Review of Resident B's Physician's orders, indicated the following: a. On 12/25/18 "Vancomycin HCI [antibiotic to treat serious bacterial infections] solution reconstituted, 1 gram [gm] IV [intravenous], infuse at 166 ml/hour [milliliters per hour] twice daily until 1/14/19" b. On 2/1/19 "Venous Doppler to right leg for edema and pain" c. On 2/2/19 "Chest x-ray 2 view for midline displacement" d. On 2/3/19 "Vital signs every shift for 72 hours, for fever and nausea x [times] 3 days" e. On 2/3/19 "Complete blood count [CBC] with diff and basic metabolic panel [BMP] 1 time for	F 0684	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident B no longer resides in facility. **Identification of other residents having the potential to be affected by the same alleged deficient practice and** **Corrective actions taken**: The Director of Nursing or designee will complete the following: 1.All residents with change of condition in the last 7 days medical record will be reviewed to ensure nursing services provided is documented in the assessments / notes and that all MD orders are administered timely. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:**	04/02/2019

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	nausea" f. On 2/3/19 "Clear liquid diet, regular texture, thin consistency for nausea" g. On 2/3/19 "Zofran 4 milligrams [mg] 1 tab by mouth 1 time for nausea" h. On 2/11/19 "Oxycodone HCI [narcotic to treat moderate to severe pain] 5 mg, give 1 tablet by mouth three times a day [TID] for pain" i. On 2/11/19 "Zofran 4 mg, give by mouth 1 time only for nausea" j. On 2/12/19 "Obtain stool sample, send to lab to check for clostridium difficile [c-diff a bacterium that causes diarrhea and inflammation of the colon]" K. On 2/12/19 "CBC with diff and complete metabolic panel [CMP] stat [as soon as possible] for infection" l. On 2/12/19 "Start IV in left arm, infuse normal saline [NS] at 70 ml/hr x 1 liter for dehydration, for 1 day, end 2/13/19" m. On 2/12/19 "Magnetic resonance imaging [MRI] to right left, from pelvis to foot, for pain diagnostic" n. On 2/12/19 "Tylenol Extra Strength 500 mg 1 tab by mouth TID for elevated temperature x 2 days" o. On 2/12/19"Chest x-ray 2 views stat for cough, for 2/12/19" p. On 2/12/19 "DuoNeb [combination bronchodilator used to treat and prevent		The Director of Nursing or designee will educate on the following: 1.The Licensed Nurses on the policies for General Hydration, Physician Orders, Notification for Change in Condition, and Administration Procedures: Intermittent Infusion Administration. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the Director of Nursing or designee: 1. Review of 5 residents 5 times per week for 2 weeks, then 1 times per week for 4 weeks, then monthly for 4 months to ensure compliance: for documentation of assessment completion and nursing services provided. 2.Review the residents with change in condition to ensure nursing services provided is documented and all orders are implemented and administered timely. This process will be ongoing as part of the daily clinical meeting.	

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	wheezing and shortness of breath] 1 vial, inhale orally four times a day [QID] for cough for 7 days" q. On 2/12/19 "Urinary Analysis [UA] with culture and sensitivity [C&S], may in and out catheter, for urinary tract infection [UTI]." r. On 2/12/19 "Diflucan [antifungal] 100 mg by mouth 1 time only for infection" s. On 2/12/19 "Swab nose for influenza [flu], end date 2/13/19" Review of Resident B's Progress Notes, indicated the following: Dated 2/11/19 at 3:46 a.m., the resident complained of nausea, the on call physician was notified, and new orders were obtained to give Zofran 4 mg x (times) 1 stat. Dated 2/11/19 at 5:10 p.m., new orders were obtained to discontinue the prn (as needed or requested) oxycodone, and start oxycodone 5 mg TID routinely. Dated 2/11/19 at 9:34 p.m., the resident complained of not feeling well, and had a temperature of 101.9 Fahrenheit (F). The physician was notified and the resident was given Tylenol. "Will continue to monitor". Dated 2/12/19 there was no documentation observed in the medical record. Dated 2/13/19 at 1:26 p.m., "Late entry for 2/12/19 2-10 p.m. Resident called 911 to go out to [hospital] emergency room. [Licensed Practical Nurse 8] spoke with resident mother on phone and she gave this nurse the information needed.		The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	Mother stated why action took place and she was sent out after 8:30 p.m. Mother stated [orders were given in the morning, nothing was being done and no one came to her and she had been sick for 2 [to] 3 days. The nurse practitioner [NP] gave orders on 2/12/19 after lunch and orders were placed in her chart and placed at the nurse's station to be taken care of by the nurse on 2 [to] 10 p.m. shift and were taken off. Resident was admitted to [hospital] for nausea, vomiting diarrhea, and abdominal pain." On 3/5/19 at 2:32 p.m., the Director of Nursing (DON) provided copies for Resident B, titled, "Progress Notes", dated 12/24/18 through 2/13/19. The notes indicated there was no documentation completed on 2/12/19. On 3/5/19 at 2:32 p.m., the DON provided copies for Resident B, and indicated they were documentation from the MD and NP, dated from 12/24/18 through 3/5/19. There was no documentation from the MD or NP dated after 1/14/19 in the resident medical record. On 3/5/19 at 2:32 p.m., the DON provided copies for Resident B, titled, "Lab-Hematology Studies", dated for March 2019. The results indicated, there was no documentation of lab studies having been completed after 2/4/19. On 3/5/19 at 4:02 p.m., the DON provided a document for Resident B, titled, "Progress Notes", dated 2/12/19, and indicated it was documentation by the Nurse Practitioner (NP). The progress note indicated the resident was seen with chief complaints of a fever, aches, joint pain, and loose stools. There was right lower extremity pain that had increased since the previous week that was warm to touch. The resident reported loose stools			

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	had started approximately 1 to 2 days previously and she was having about 2 loose stools a day. The stool had a strong odor that morning. The resident reported a cough and congestion that had started about 3 days previously, with a fever and non-productive cough. The NP ordered stat labs, a chest x-ray, new medications, and medication changes. During an interview, on 3/5/19 at 12:20 p.m., the DON indicated, she was not sure why Resident B discharged herself to the hospital. Lab tests had been ordered for the resident, they were not completed, but if they were not written as stat, they could have been completed as late as the next day. The IV should have been started as soon as possible, there was no documentation why it had not been started. The nurse should have written a progress note when the NP gave new orders, and when the orders had been completed. The DON acknowledged there was no documentation in the resident's medical record on 2/12/19 to indicate the resident's change in condition, an assessment by the nurse, or the physician being notified. There was no documentation the resident had left the facility, her condition at the time she left, or that the physician was notified the resident had admitted herself to the hospital. During an interview, on 3/5/19 at 12:27 p.m., the Regional Director of Operation indicated there should have been documentation in Resident's B's medical record to indicate her change of condition to coincide with the new physician's orders. There was no documentation observed in the resident record on 2/12/19. During an interview, on 3/5/19 at 1:50 p.m., the NP indicated Resident B was seen on 2/12/19 at			

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	approximately 8:30 a.m., as her first resident of the day. The resident voiced concerns regarding nausea, vomiting, diarrhea with a foul odor, burning with urination, having a cough, upper right arm pain, leg pain, and she had been running a temperature. The NP wrote new orders to include: an IV to replace fluids related to dehydration from the diarrhea and temperature, a MRI to the leg due to recent Doppler testing had already been completed with negative results, a flu test related to her symptoms and the flu was going around, a UA due to the resident complaints of burning with urination, a chest x-ray for her cough and temperature, and stool sample testing was ordered as the resident most likely had C-diff due to recent antibiotic use. The NP indicated, she ordered the labs to be completed stat to make sure the labs were completed on that date, 2/12/19. A progress note was written. On 3/5/19 at 3:25 p.m., the Regional Director of Clinical Operations, provided documents for Resident B, titled, ""Weights and Vital Summary", dated February 2019. The records indicated, there was no documentation of vital signs to include temperatures recorded on 2/12/19. On 3/5/19 at 2:32 p.m., the DON provided a policy, titled, "General Hydration Services", dated 4/1/16. The policy indicated, "It is the policy of this facility to promote resident centered care by providing adequate fluids for hydration in consideration of health needs and resident preferences. 1. Assess the resident's nutritional and health status needs for proper amount, type and proper consistency of fluids. For changes or updates: a. Modify the care plan. b. Notify the dietary services manager. c. Notify staff of changes ...3. Observe eating and drinking providing modifications as needed ....7. Update			

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	care plans and notify family of changes as appropriate." On 3/5/19 at 2:32 p.m., the DON provided a policy, titled, "Physician Orders", dated 12/1/18. The policy indicated, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents ...The purpose of this policy is to provide guidance for licensed nurse and licensed therapist to accurately document physician and provider orders as determined by the licensee's Scope of Practice. For the purpose of this policy and other policies at this facility, the term physician or provider also includes all approved providers that have the authority to write medical orders. This includes but may not be limited to physicians, nurse practitioners [NP's]...I. Medical Order Transcription. a. The provider may write the order in the medical record. b. A provider may give a medical order over the phone. i. The nurse will transcribe the order on the Telephone order slip ....c. The provider may send a signed and dated fax medical order. d. Verbal orders are accepted but will be written out by the nurse as soon as practicable ...III. Execution of the Order and Notifications. a. The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse. i. Contact laboratory services, radiology services, pharmacy services, therapy or other outside vendors as required to execute the medical order. ii. Update Medication Administration Record/Treatment Administration Record [MAR/TAR] with changes as appropriate. iv. Notify resident/resident representative of changes or new orders as appropriate. v. Notify attending or other providers as appropriate. vi. Document contacts in the medical record."			

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	On 3/5/19 at 3:25 p.m., the Regional Director of Clinical Operations, provided a policy, titled, "Notification for Changes in Condition", dated 11/30/18. The policy indicated, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents ...The purpose of this policy is to provide guidance for notifications made to residents, resident representatives, and family for resident changes in condition. Changes may include but are not limited to accidents, incidents, transfers, changes in overall health status, significant medical changes, therapy services changes, transfer, hospitalizations, or death ....Federal regulation ...addresses the for notification of physician, family or significant changes ...Nurses will be skilled at identifying changes in condition for a resident based upon their needs, medical status, and report those changes to the Unit Manager/designee. i. For immediate change needs when no UM is on duty, the nurse will use good clinical judgement to call the MD or their supervisor if uncertain in a change in condition. ii. For emergency purposes, transfers to acute care may require the notifications be made after the resident is transferred to the hospital. 1. The nurse should secure the name and address of the hospital to provide to the resident representative/authorized family member[s] ...Physician notification and communication. 1. May use Situation/Background/Assessment/Recommendation [SBAR] or other Interact tools ...2. Document in the electronic medical record ....c. Notifications that are for emergency situations, require immediate notification as soon as time permits ...1. Transfer to hospital 2. Severe change in physical or mental status 3. Unexpected death. III. Timing and Documentation of notifications. a.			

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	Notifications will be prioritized when competing changes occur. b. The attending practitioner must be immediately notified of significant changes in condition, and the medical record must reflect the notification, response and interventions implemented to address the resident's condition. c. The nurse will record in the progress notes, the name of person called, the time of each attempt to contact, and the telephone number[s] attempted ..." On 3/5/19 at 5:02 p.m., the DON provided a policy, titled, "Administration Procedures: Intermittent Infusion Administration", dated 12/2014. The policy indicated, "Once a physician's order for intermittent infusion therapy is obtained, the nurse must verify the identity of the patient and order the medication. A physician's order is required to discontinue intravenous therapy except when the IV must be discontinued temporarily due to problems with venous access device ...1. Bring medication to room temperature by removing it from the refrigerator 30 minutes before administering. 2. Identify the medication to be administered and the correct patient. 3. Explain to the patient the rationale of the medication ordered and the procedure ...18. Document the dose given on the medication administration record as well as any IV site complications/concerns and patient's tolerance of procedure in the nurse's notes." This Federal tag relates to Complaint IN00288504. 3.1-37			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy			

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	tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to provide intravenous fluids for 1 of 3 residents reviewed for dehydration (Resident B). Findings include: Record review was completed for Resident B on 3/5/19 at 9:49 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic hepatitis, cirrhosis of liver, pain in unspecified joint, methicillin-resistant staphylococcus aureus (MRSA a bacterial infection resistant to many antibiotics), and elevated white blood count. Review of Resident B's Physician's order, dated 2/12/19, indicated "Start IV [intravenous] in left arm, infuse normal saline at 70 ml/hr [milliliters per hour] x [times] 1 liter for dehydration, for 1 day, end 2/13/19" and "Tylenol Extra Strength 500 mg	F 0692	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident B no longer resides in facility. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: The Director of Nursing or designee will complete the following: 1.Review all residents with IV hydration orders within the last 7 days to ensure IV are being provided as ordered.	04/02/2019

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	[milligram] 1 tab by mouth TID [three times a day] for elevated temperature x 2 days" Review of Resident B's Progress Notes indicated the following: Dated 2/11/19 at 3:46 a.m., indicated the resident complained of nausea. The physician was notified and new orders were obtained to give Zofran 4 mg one dose stat (immediately). Dated 2/11/19 at 9:34 p.m., the resident complained of not feeling well, and had a temperature of 101.9 Fahrenheit (F). The physician was notified and the resident was given Tylenol. "Will continue to monitor". Dated 2/13/19 at 1:26 p.m., "Late entry for 2/12/19 2-10 p.m. Resident called 911 to go out to [hospital] emergency room. [Licensed Practical Nurse 8] spoke with resident mother on phone and she gave this nurse the information needed. Mother stated why action took place and she was sent out after 8:30 p.m. Mother stated [orders were given in the morning, nothing was being done and no one came to her and she had been sick for 2 [to] 3 days. The nurse practitioner [NP] gave orders on 2/12/19 after lunch and orders were placed in her chart and placed at the nurse's station to be taken care of by the nurse on 2 [to] 10 p.m. shift and were taken off. Resident was admitted to [hospital] for nausea, vomiting diarrhea, and abdominal pain." On 3/5/19 at 4:02 p.m., the DON provided a document for Resident B, titled "Progress Notes", dated 2/12/19, and indicated it was documented by the Nurse Practitioner (NP). The progress note indicated, the resident was seen with chief complaints of a fever, aches, joint pain, and loose		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Director of Nursing or designee will in-service the Licensed Nurses on the following policies: 1.General Hydration Services 2.Physician Orders 3.Administration Procedures: Intermittent Infusion Administration **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the Director of Nursing or designee: 1.Review of all residents with IV hydration orders 5 times per week for 2 weeks, then 1 times per week for 4 weeks, then monthly for 4 months to ensure compliance: review to ensure they have been administered as ordered. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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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
	stools. There was right lower extremity pain that had increased since the previous week that was warm to touch. The resident reported loose stools had started approximately 1 to 2 days previously and she was having about two loose stools a day. The resident reported a cough and congestion that had started about three days previously, with a fever and non-productive cough. The NP ordered stat labs, a chest x-ray, new medications, and medication changes. During an interview, on 3/5/19 at 12:20 p.m., the DON indicated she was not sure why Resident B discharged herself to the hospital. The IV should have been started as soon as possible, there was no documentation why it had not been started. The nurse should have written a progress note when the NP gave new orders and then when the orders had been completed. The DON acknowledged there was no documentation in the resident's medical record, for 2/12/19, to indicate the resident's change in condition, an assessment by the nurse, or the physician being notified. During an interview, on 3/5/19 at 12:27 p.m., the Regional Director of Operation indicated there should have been nursing documentation in Resident's B's medical record to indicate her change of condition to coincide with the new physician's orders. There was no documentation observed in the resident record on 2/12/19. During an interview, on 3/5/19 at 1:50 p.m., the NP indicated Resident B was seen on 2/12/19 at approximately 8:30 a.m., as her first resident of the day. The resident voiced concerns regarding nausea, vomiting, diarrhea with a foul odor, burning with urination, having a cough, upper right arm pain, leg pain, and she had been running a temperature. The NP wrote new orders to			

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	155664	A. BUILDING 00 B. WING	03/05/2019

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	include, but were not limited to, an IV to replace fluids related to dehydration from the diarrhea and temperature. She ordered the labs to be completed stat to make sure the labs were completed on that date, 2/12/19. On 3/5/19 at 3:25 p.m., the Regional Director of Clinical Operations, provided documents for Resident B. The records lacked documentation of the resident's vital signs or temperatures on 2/12/19. On 3/5/19 at 2:32 p.m., the DON provided a policy, titled, "General Hydration Services", dated 4/1/16. The policy indicated, "It is the policy of this facility to promote resident centered care by providing adequate fluids for hydration in consideration of health needs and resident preferences...Assess the resident's nutritional and health status needs for proper amount, type and proper consistency of fluids..." On 3/5/19 at 2:32 p.m., the DON provided a policy, titled, "Physician Orders", dated 12/1/18. The policy indicated, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents ...The purpose of this policy is to provide guidance for licensed nurse and licensed therapist to accurately document physician and provider orders as determined by the licensee's Scope of Practice. For the purpose of this policy and other policies at this facility..Execution of the Order and Notifications. a. The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse...Update Medication Administration Record/Treatment Administration Record [MAR/TAR] with changes as appropriate..."			

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	On 3/5/19 at 5:02 p.m., the DON provided a policy, titled, "Administration Procedures: Intermittent Infusion Administration", dated 12/2014. The policy indicated, "Once a physician's order for intermittent infusion therapy is obtained, the nurse must verify the identity of the patient and order the medication...Document the dose given on the medication administration record as well as any IV site complications/concerns and patient's tolerance of procedure in the nurse's notes." This Federal tag relates to Complaint IN00288504. 3.1-46			