STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
		155664				10/19/	₂₀₂₀
				CENTER	ADDRESS OF A STATE OF CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
		DE CENTED	4102 SHORE DR				
EAGLE C	REEK HEALTHCA	ARE CENTER	INDIANAPOLIS, IN 46254				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)			DATE	
F 0000							
Bldg. 00							
This visit was for the Investigation of Complaint		F 00	000				
	IN00339423. This	visit included a COVID-19					
	Focused Infection (Control Survey.					
	*	9423- Substantiated.					
		encies related to the					
	allegations are cited	d at F880.					
	Survey dates: Octo	ber 16 and 19, 2020.					
	Facility number: 010666						
	Provider number: 1						
	AIM number: 2002	29930					
	Canana Dad Tama						
	Census Bed Type: SNF/NF: 81						
	Total: 81						
	101.01						
	Census Payor Type						
	Medicare: 9	·•					
	Medicaid: 61						
	Other: 11						
	Total: 81						
	This deficiency refl	lects State Findings cited in					
	accordance with 41						
	Quality review was	completed on October 22,					
	2020.						
F 0880	483.80(a)(1)(2)(4)						
SS=D	Infection Preventi						
Bldg. 00	§483.80 Infection						
	_	establish and maintain an					
	-	on and control program					
		de a safe, sanitary and					
	comfortable environment	onment and to help prevent					
1	1		1		i		I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155664	B. W	ING		10/19/	/2020
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
E401 E 4		DE OENTED		1	HORE DR		
EAGLE CREEK HEALTHCARE CENTER				INDIAN	APOLIS, IN 46254		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	16	DATE
	the development a	and transmission of					
communicable diseases and infections.							
	§483.80(a) Infecti	on prevention and control					
	program.						
	The facility must e	establish an infection					
	prevention and co	entrol program (IPCP) that					
	I -	minimum, the following					
	elements:	-					
	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and						
	controlling infections and communicable						
	diseases for all re	sidents, staff, volunteers,					
	visitors, and other	individuals providing					
	services under a	contractual arrangement					
	based upon the fa	cility assessment					
	conducted accord	ing to §483.70(e) and					
	following accepted	d national standards;					
	§483.80(a)(2) Wri	tten standards, policies,					
	and procedures fo	or the program, which must					
	include, but are no	ot limited to:					
	(i) A system of sur	rveillance designed to					
	identify possible of	communicable diseases or					
	infections before t	hey can spread to other					
	persons in the fac	ility;					
	(ii) When and to w	hom possible incidents of					
	communicable dis	sease or infections should					
	be reported;						
	(iii) Standard and	transmission-based					
	precautions to be	followed to prevent spread					
	of infections;						
	(iv)When and how	isolation should be used					
		uding but not limited to:					
	(A) The type and	duration of the isolation,					
	depending upon the	he infectious agent or					
	organism involved	d, and					
	(B) A requirement	that the isolation should be					
	the least restrictive	e possible for the resident					

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Event ID:

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Facility ID: 010666

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155664	B. WI	B. WING 10/19			2020
				CTDEET A	ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
		DE CENTED			HORE DR		
EAGLE	REEK HEALTHCA	ARE CENTER		INDIANAPOLIS, IN 46254			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	under the circumstances.						
	(v) The circumstar	nces under which the					
	facility must prohil	bit employees with a					
	communicable dis	sease or infected skin					
	lesions from direc	t contact with residents or					
	their food, if direct	t contact will transmit the					
	disease; and						
	(vi)The hand hygi	ene procedures to be					
	followed by staff in	nvolved in direct resident					
	contact.						
		ystem for recording					
	incidents identified under the facility's IPCP						
	and the corrective actions taken by the						
	facility.						
	§483.80(e) Linens						
		andle, store, process, and					
	-	o as to prevent the spread					
	of infection.						
	§483.80(f) Annual						
	-	nduct an annual review of					
	=	ate their program, as					
	necessary.						
		on, interview and record	F 08	880	F 880 A Directed Plan of		10/30/2020
	-	failed to ensure a resident on			Correction (DPOC)		
		pecial precautions to prevent			A.Specific/Immediate:		
	, .	s in tiny droplets caused by			Immediately implement spec	ITIC	
		zing) precautions remained in			plan for		
		COVID-19 pandemic for 1			resident/residents/area/other		
		wed for infection control			identified in the deficiency to	'	
	(Resident C).				correct.		
	Planting to 1 days				4. The Director of Nursing / ID	,	
	Finding includes:				1. The Director of Nursing / IP	1	
	On 10/16/20 : 4.11 /	54 a.m. Dazidant D			designee will ensure the		
		54 a.m., Resident B was			resident/residents affected has		
		g himself down the hallway,			been isolated in Transmission		
	-	sk. His room was observed			Based Precautions according		
	with a personal pro	tective equipment (PPE)			CDC and IP recommendations	3	

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Event ID:

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Facility ID: 010666

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. Bl	A. BUILDING <u>00</u> COMPLETED			D	
		155664	B. W	ING		10/19/202	20	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
					HORE DR			
EAGLE (CREEK HEALTHC	ARE CENTER		INDIANAPOLIS, IN 46254				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	organizer hanging	on the door, and a sign			and ensure care giving staff a	·e		
	indicated isolation	(special precautions to			educated on isolation			
	prevent the spread	of germs) precautions were			procedures. Ensure all staff a	re		
	required. At the sa	me time, Resident B indicated			aware of who is on isolation and			
	he had just returne	d to the hall from the therapy			appropriate signage			
	gym. Resident B w	vas not required to be in			implemented.			
	isolation precautio	ns, but his roommate was.			Policy / Procedure - Criter	ia		
	Resident B continu	ned to propel himself down to			for Covid 19 Isolation			
	the nurse's station,	spoke to Licensed Practical			2. The Director of Nursing / IP	1		
	Nurse (LPN) 4, the	en returned to his room. LPN			designee will ensure			
	4 did not instruct F	Resident B to return to his			resident/residents participating	j in		
	room or say anythi	ing about isolation precautions			communal dining or activities	are		
	being required.				social distancing and wearing			
					face covering. If resident can	not		
	Resident B's record	d was reviewed on 10/16/20 at			tolerate face covering, ensure			
	12:54 p.m. Census	information indicated the			social distancing and education	n.		
	resident was admit	ted to the facility on 10/2/20.			Ensure all care giving staff are			
					trained on when and how to so	ocial		
	A Physician's Orde	er, dated 10/2/20, indicated the			distance and encourage			
	resident required s	trict droplet isolation			application of face coverings for	or		
	precautions and wa	as not to leave his room.	the residents. Follow CDC and					
					facility policy.			
	A Physician's Orde	er, dated 10/3/20, indicated the			IN Covid 19 Back on			
	resident received p	physical therapy (PT) five			Track Guidelines - updated			
	times a week.				10/20/2020			
		er, dated 10/6/20, indicated the						
	resident received s	peech therapy (ST) five times			B. Systemic			
	a week.							
					1). A root cause analysis (RCA	<i>'</i>		
		er, dated 10/6/20, indicated the			was conducted by the compar	•		
		occupational therapy (OT) five			Division (Consultant) Infection			
	times a week.				Preventionist (IP), with input a			
					review from the Medical Direc			
	_	10/15/20, indicated the			IP, Executive Director, Directo	r of		
		c for COVID-19. Interventions			Nursing, Assistant Director of	_ [
		not limited to, droplet			Nursing and Regional Director			
	isolation precautio	ns.			Clinical Operations to determine	пе		
					the root cause resulting in the			
During an interview, on 10/16/20 at 12:01 p.m.,					facilities Infection Control			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155664	B. Wl	ING		10/19/	2020
N4. 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	DROLUBER OF SUPE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	K			HORE DR		
EAGLE (CREEK HEALTHCA	ARE CENTER		INDIANAPOLIS, IN 46254			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		esident B was on isolation			citation.		
	precautions because he was admitted to the				a). The Leadership team faile		
	facility in the last 14 days. He was allowed to				provide education to the facilit	-	
		e wished and went to the			nursing staff on the policy and		
	therapy gym for the	erapy.			procedure for Criteria for Covi	d –	
					19 Isolation		
	During an interview, on 10/16/20 at 12:30 p.m.,				The facility leadership team fa	illed	
	Physical Therapy Assistant (PTA) 13 indicated				to make facility rounds /		
	each day, therapy staff received a list of all				observations and enforce		
	_	ired isolation precautions. The			corrections noted to be deficie	ent	
	residents on the list were treated in their rooms.				infection control observations		
	Residents isolated related to being newly				l., <u>-</u>		
	admitted to the facility were treated in their				b). The solutions and system	IC	
		was not admitted with an			changes developed by the		
		he was able to move freely			Division (Consultant IP), DON	,	
	-	lity and received therapy in			ADON and facility IP include:		
		e received therapy in the			The Director of Nursing / IP /		
		he was admitted. Resident B			designee will ensure the		
	-	not have been included on the			resident/residents affected ha		
		lents because he was allowed			been isolated in Transmission		
		At the same time, Certified			Based Precautions according		
	_	apy Assistant (COTA) 14			CDC and IP recommendation	-	
		d Resident B this morning, in			and ensure care giving staff a	re	
	the therapy gym.				educated on isolation		
	Daning as into :	10/16/20 -4 2:10			procedures. Ensure all staff a		
	_	v, on 10/16/20 at 3:10 p.m.,			aware of who is on isolation a	IIU	
		sing (DON) indicated ed and on droplet isolation			appropriate signage		
	•	•			implemented.	rio	
		days, following admission to			Policy / Procedure - Criter for Covid 19 Isolation	ııd	
		ble to leave their rooms to go					
		dents wore masks to the			The Director of Nursing / IP / designee will ensure		
		herapy staff work masks and eresident was allowed in the			resident/residents participating	n in	
	. –	me and the gym was cleaned			communal dining or activities	-	
	between uses.	me and the gym was cleaned			social distancing and wearing	ai C	
	between uses.				face covering. If resident can	not	
	On 10/16/20 at 2:49	5 p.m., the Executive			tolerate face covering, ensure		
		ided a document titled,			social distancing and education		
	` ' *	D-19 Isolation," and indicated			Ensure all care giving staff are		
		irrently being used by the			trained on when and how to s		
	it was the policy cu	menny being used by the			i anieu on when and now to s	ociai	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION	î ´			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W	UILDING	00			
		155664	B. W	ING		10/19/	2020	
NAME OF P	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR					
EAGLE C	CREEK HEALTHCA	RE CENTER		INDIAN	APOLIS, IN 46254			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	complete Date reference eese eed eere build of will like the like	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		indicated "At Risk for			distance and encourage			
		his unit will be used for			application of face coverings f			
	-	be at risk for developing			the residents. Follow CDC an	d		
		s new admits, residents who			facility policy.			
	-	but not showing signs and			IN Covid 19 Back on Track Guidelines - updated			
		mission Criteria: 1. New			-			
		arge Criteria: 1. Once a days with no signs and			10/20/2020			
	symptoms they may	-						
		t Risk' unit: 1. The unit will						
	be identified as the 'at risk' or 'yellow' unit. 2.				The DON, IP, or designated			
	Full PPE will be used while working on the unit.				facility leadership will conduct	full		
Full PPE consist of N95 mask, gloves, gown, and					/ all department facility rounds			
	eye covers13. Therapy can still be performed				observations at a minimum of			
	-	e following process: a. All			daily: observe that the staff			
		w the same guidelines as the			ensure residents in droplet			
	nursing staff as liste	ed above. bThe therapist			precautions remain in their roo	om		
	should try to work t	these visits in at the end of			during the Covid 19 pandemic	for		
	their day as much a	s possible"			the MD ordered amount of time	е		
					and enforce corrective measu	res		
	This Federal tag rel	ates to complaint			and education if deficiencies a	ire		
	IN00339423.				observed			
	2 1 19(b)(2)							
	3.1-18(b)(2)				2). The DON, IP Nurse and			
					Division (Consultant) IP review	hav		
					the LTC Infection Control	vcu		
					Self-Assessment. Changes w	ere		
					made to so the assessment w			
					now be an accurate reflection			
					the facility. This assessment	will		
					be submitted with the DPOC			
					documentation.			
					C. Training:			
					1) Dor the LTC infection action			
					1).Per the LTC infection control assessment review and revision			
					by the Division (Consultant) IF			
					by the Division (Consultant) IF	,		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/19/2020			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR					
EAGLE C	REEK HEALTHCA	RE CENTER	INDIAN	IAPOLIS, IN 46254				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				facility IP and DON. The follotraining needs were identified and implemented by the Divis (Consultant) IP to the facility I and DON with training resource and polices provided and submitted as part of the DPO documentation. 1.Infection Surveillance (Section D) the facility staff cademonstrate knowledge of whand to whom to report communicable diseases, healthcare associated infection and potential outbreaks. The facility has a current plan of correction in progress. Hand Hygiene (section F) - the facility has hand hygiene police to promote preferential use of ABHR, personnel performance hand hygiene. The facility has plan of correction in progress. Standard Precautions Tracer (Section G) gloves are change and hand hygiene performed before moving from a contaminated body site to a cobody site during care, PPE is appropriately discarded after resident care, prior to leaving room, followed by hand hygien The facility has a plan of correction in progress. Transmission Based Precauti (Section H) - hand hygiene is	ion P ces C an nen en en cies e of s a ed lean the ne.			

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155664		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/19/2020			
NAME OF P	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE					
EAGLE C	REEK HEALTHCA	RE CENTER	4102 SHORE DR INDIANAPOLIS, IN 46254					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
				performed before entering a resident care environment, gland gowns are donned upon into the environment of reside on precautions, gloves and gare removed and properly discarded and hand hygiene performed before leaving the resident care environment. Tacility has a plan of correction progress.	entry ent owns is			
				2). Per the RCA completed be Division (Consultant) IP, Med Director, IP, Executive Director of Nursing, Assistant Director of Nursing and Region Director of Clinical Operation the following training needs with identified and implemented be Division (Consultant) IP to the facility IP and DON with training resources and polices provide and submitted as part of the DPOC documentation.	ical or, conal s, vere by the e			
				The Director of Nursing / IP / designee will ensure the resident/residents affected had been isolated in Transmission Based Precautions according CDC and IP recommendation and ensure care giving staff a educated on isolation procedures. Ensure all staff aware of who is on isolation appropriate signage implemented. Policy / Procedure - Crite	as n i to as are are and			

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6IMN11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED	
		155664	B. WI	NG		10/19/	2020	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER		4102 SHORE DR					
EAGLE C	CREEK HEALTHCA	RE CENTER	INDIANAPOLIS, IN 46254					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					for Covid 19 Isolation			
					The Director of Nursing / IP /			
					designee will ensure			
					resident/residents participating			
					communal dining or activities a	are		
					social distancing and wearing	-4		
					face covering. If resident cann	10t		
					tolerate face covering, ensure	n		
					social distancing and educatio			
					Ensure all care giving staff are trained on when and how to so			
					distance and encourage	Julai		
					application of face coverings for	nr l		
					the residents. Follow CDC an			
					facility policy.	u		
					IN Covid 19 Back on			
					Track Guidelines - updated			
					10/20/2020			
					The DON, IP, or designated			
					facility leadership will conduct	full		
					/ all department facility rounds			
					observations at a minimum of			
					daily: observe that the staff			
					ensure residents in droplet			
					precautions remain in their roc	m		
					during the Covid 19 pandemic	for		
					the MD ordered amount of time	e		
					and enforce corrective measur	res		
					and education if deficiencies a	re		
					observed			
						_		
					D. Monitoring: Monitoring o			
					approaches to ensure Infecti	on		
					Control Practices are			
					maintained.			
					The DON, IP, or designated			
					facility leadership will conduct			
					facility / all department rounds	1		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 10/19/2020			
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				observations at a minimum of daily for 6 weeks and until compliance is maintained: observe that the staff ensure residents in droplet precaution remain in their room during the Covid 19 pandemic for the ME ordered amount of time and enforce corrective measures are education if deficiencies are observed The DON, IP, or designated facility leadership will completed daily visual rounds throughout facility to ensure staff are practicing appropriate Infection Control Practices. This will offor 6 weeks and until compliant is maintained. E. Quality Assurance and Performance Improvement (QAPI): The IP Nurse/Director of Nurse will present the results of these audits monthly to the QAPI committee for no less than 6 months. The facility through the QAPI program will review, upon and make changes to the DPC as needed for sustaining substantial compliance for no than 6 months. Any patterns are identified will have an Activation of the Plan initiated. The QAPI committee will determine whe 100% compliance is achieved if ongoing monitoring is required.	e tithe n ccurnce ling e he date OC less that on n or			

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-		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/19/2020	
NAME OF PROVIDER OR SUPPLIER EAGLE CREEK HEALTHCARE CENTER				4102 SI	ADDRESS, CITY, STATE, ZIP CODE HORE DR APOLIS, IN 46254	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY) TAG DEFICIENCY)			ATE	(X5) COMPLETION DATE

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