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	10/19/2020

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

(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 IN00339423. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00339423- Substantiated. Federal/state deficiencies related to the allegations are cited at F880. Survey dates: October 16 and 19, 2020. Facility number: 010666 Provider number: 155664 AIM number: 200229930 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 9 Medicaid: 61 Other: 11 Total: 81 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 22, 2020.	F 0000		
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent			

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

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	10/19/2020

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

(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
	the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease 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 for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident			

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	10/19/2020

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

(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
	under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to ensure a resident on droplet isolation (special precautions to prevent the spread of germs in tiny droplets caused by coughing and sneezing) precautions remained in their room during a COVID-19 pandemic for 1 of 3 residents reviewed for infection control (Resident C). Finding includes: On 10/16/20 at 11:54 a.m., Resident B was observed propelling himself down the hallway, wearing a cloth mask. His room was observed with a personal protective equipment (PPE)	F 0880	F 880 A Directed Plan of Correction (DPOC) **A.Specific/Immediate: Immediately implement specific plan for resident/residents/area/others identified in the deficiency to correct.** 1. The Director of Nursing / IP / designee will ensure the resident/residents affected has been isolated in Transmission Based Precautions according to CDC and IP recommendations	10/30/2020

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	10/19/2020

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

(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
	organizer hanging on the door, and a sign indicated isolation (special precautions to prevent the spread of germs) precautions were required. At the same time, Resident B indicated he had just returned to the hall from the therapy gym. Resident B was not required to be in isolation precautions, but his roommate was. Resident B continued to propel himself down to the nurse's station, spoke to Licensed Practical Nurse (LPN) 4, then returned to his room. LPN 4 did not instruct Resident B to return to his room or say anything about isolation precautions being required. Resident B's record was reviewed on 10/16/20 at 12:54 p.m. Census information indicated the resident was admitted to the facility on 10/2/20. A Physician's Order, dated 10/2/20, indicated the resident required strict droplet isolation precautions and was not to leave his room. A Physician's Order, dated 10/3/20, indicated the resident received physical therapy (PT) five times a week. A Physician's Order, dated 10/6/20, indicated the resident received speech therapy (ST) five times a week. A Physician's Order, dated 10/6/20, indicated the resident received occupational therapy (OT) five times a week. A care plan, dated 10/15/20, indicated the resident was at risk for COVID-19. Interventions included, but were not limited to, droplet isolation precautions. During an interview, on 10/16/20 at 12:01 p.m.,		and ensure care giving staff are educated on isolation procedures. Ensure all staff are aware of who is on isolation and appropriate signage implemented. Policy / Procedure - Criteria for Covid 19 Isolation 2. The Director of Nursing / IP / designee will ensure resident/residents participating in communal dining or activities are social distancing and wearing face covering. If resident cannot tolerate face covering, ensure social distancing and education. Ensure all care giving staff are trained on when and how to social distance and encourage application of face coverings for the residents. Follow CDC and facility policy. IN Covid 19 Back on Track Guidelines - updated 10/20/2020 **B. Systemic** 1). A root cause analysis (RCA) was conducted by the company Division (Consultant) Infection Preventionist (IP), with input and review from the Medical Director, IP, Executive Director, Director of Nursing, Assistant Director of Nursing and Regional Director of Clinical Operations to determine the root cause resulting in the facilities Infection Control	

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	10/19/2020

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

(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
	LPN 4 indicated Resident B was on isolation precautions because he was admitted to the facility in the last 14 days. He was allowed to leave his room as he wished and went to the therapy gym for therapy. During an interview, on 10/16/20 at 12:30 p.m., Physical Therapy Assistant (PTA) 13 indicated each day, therapy staff received a list of all residents who required isolation precautions. The residents on the list were treated in their rooms. Residents isolated related to being newly admitted to the facility were treated in their rooms. Resident B was not admitted with an active infection, so he was able to move freely throughout the facility and received therapy in the therapy gym. He received therapy in the therapy gym since he was admitted. Resident B most likely would not have been included on the list of isolated residents because he was allowed to leave his room. At the same time, Certified Occupational Therapy Assistant (COTA) 14 indicated she treated Resident B this morning, in the therapy gym. During an interview, on 10/16/20 at 3:10 p.m., the Director of Nursing (DON) indicated residents quarantined and on droplet isolation precautions for 14 days, following admission to the facility, were able to leave their rooms to go to therapy. The residents wore masks to the therapy gym. The therapy staff work masks and eye protection. One resident was allowed in the therapy gym at a time and the gym was cleaned between uses. On 10/16/20 at 2:45 p.m., the Executive Director (ED) provided a document titled, "Criteria for COVID-19 Isolation," and indicated it was the policy currently being used by the		citation. a). The Leadership team failed to provide education to the facility nursing staff on the policy and procedure for Criteria for Covid – 19 Isolation The facility leadership team failed to make facility rounds / observations and enforce corrections noted to be deficient infection control observations b). The solutions and systemic changes developed by the Division (Consultant IP), DON, ADON and facility IP include: The Director of Nursing / IP / designee will ensure the resident/residents affected has been isolated in Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Ensure all staff are aware of who is on isolation and appropriate signage implemented. Policy / Procedure - Criteria for Covid 19 Isolation The Director of Nursing / IP / designee will ensure resident/residents participating in communal dining or activities are social distancing and wearing face covering. If resident cannot tolerate face covering, ensure social distancing and education. Ensure all care giving staff are trained on when and how to social	

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	10/19/2020

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

(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
	facility. The policy indicated "...At Risk for COVID-19 Unit: This unit will be used for residents who may be at risk for developing COVID-19, such as new admits, residents who have been exposed, but not showing signs and symptoms, etc. Admission Criteria: 1. New admissions...Discharge Criteria: 1. Once a resident reaches 14 days with no signs and symptoms they may move off of the unit...Process for 'At Risk' unit: 1. The unit will be identified as the 'at risk' or 'yellow' unit. 2. Full PPE will be used while working on the unit. Full PPE consist of N95 mask, gloves, gown, and eye covers...13. Therapy can still be performed on this unit with the following process: a. All therapist must follow the same guidelines as the nursing staff as listed above. b....The therapist should try to work these visits in at the end of their day as much as possible...." This Federal tag relates to complaint IN00339423. 3.1-18(b)(2)		distance and encourage application of face coverings for the residents. Follow CDC and facility policy. 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 room during the Covid 19 pandemic for the MD ordered amount of time and enforce corrective measures and education if deficiencies are observed 2). The DON, IP Nurse and Division (Consultant) IP reviewed the LTC Infection Control Self-Assessment. Changes were made to so the assessment would now be an accurate reflection of the facility. This assessment will be submitted with the DPOC documentation. **C. Training:** 1).Per the LTC infection control assessment review and revision by the Division (Consultant) IP,	

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	10/19/2020

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

(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
			facility IP and DON. The following training needs were identified and implemented by the Division (Consultant) IP to the facility IP and DON with training resources and polices provided and submitted as part of the DPOC documentation. 1.Infection Surveillance (Section D) the facility staff can demonstrate knowledge of when and to whom to report communicable diseases, healthcare associated infections and potential outbreaks. The facility has a current plan of correction in progress. Hand Hygiene (section F) - the facility has hand hygiene policies to promote preferential use of ABHR, personnel performance of hand hygiene. The facility has a plan of correction in progress. Standard Precautions Tracer (Section G) gloves are changed and hand hygiene performed before moving from a contaminated body site to a clean body site during care, PPE is appropriately discarded after resident care, prior to leaving the room, followed by hand hygiene. The facility has a plan of correction in progress. Transmission Based Precautions (Section H) - hand hygiene is	

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	10/19/2020

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

(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
			performed before entering a resident care environment, gloves and gowns are donned upon entry into the environment of resident on precautions, gloves and gowns are removed and properly discarded and hand hygiene is performed before leaving the resident care environment. The facility has a plan of correction in progress. 2). Per the RCA completed by the Division (Consultant) IP, Medical Director, IP, Executive Director, Director of Nursing, Assistant Director of Nursing and Regional Director of Clinical Operations, the following training needs were identified and implemented by the Division (Consultant) IP to the facility IP and DON with training resources and polices provided and submitted as part of the DPOC documentation. The Director of Nursing / IP / designee will ensure the resident/residents affected has been isolated in Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Ensure all staff are aware of who is on isolation and appropriate signage implemented. Policy / Procedure - Criteria	

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	10/19/2020

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

(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
			for Covid 19 Isolation The Director of Nursing / IP / designee will ensure resident/residents participating in communal dining or activities are social distancing and wearing face covering. If resident cannot tolerate face covering, ensure social distancing and education. Ensure all care giving staff are trained on when and how to social distance and encourage application of face coverings for the residents. Follow CDC and facility policy. 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 room during the Covid 19 pandemic for the MD ordered amount of time and enforce corrective measures and education if deficiencies are observed **D. Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained.** The DON, IP, or designated facility leadership will conduct full facility / all department rounds /	

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	10/19/2020

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

(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
			observations at a minimum of daily for 6 weeks and until compliance is maintained: observe that the staff ensure residents in droplet precautions remain in their room during the Covid 19 pandemic for the MD ordered amount of time and enforce corrective measures and education if deficiencies are observed The DON, IP, or designated facility leadership will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices. This will occur for 6 weeks and until compliance is maintained. **E. Quality Assurance and Performance Improvement (QAPI):** The IP Nurse/Director of Nursing 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, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	10/19/2020

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

(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