DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	05/17/2019

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00294407. Complaint IN00294407 - Unsubstantiated due to lack of evidence. Survey dates: May 13, 14,15, 16, and 17, 2019. Facility number: 010666 Provider number: 155664 AIM number: 200229930 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 7 Medicaid: 39 Other: 23 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 28, 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 Recertification and State Licensure survey on March 17, 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 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview and record review, the facility failed to protect residents privacy, and maintain residents dignity by not pulling a privacy curtain and/or closing the Resident's door during care, (Resident 58), as	F 0550	Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident 58 curtain to be pulled when being assessed or given	06/14/2019

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	another resident passed by and stopped to watch (Resident 78), and by completing an assessment in the main dining room during meal service, (Resident 12). This deficient practice had the potential to effect 2 of 3 residents reviewed for dignity. Findings include: 1. On 5/15/19 at 11:00 a.m., Resident 58 was observed lying on her back in bed. She had a tube feed connected, and running continuously. She was grimacing, squirming, kicking her legs back and forth, and calling out, "I need to throw up" repeatedly. On 5/15/19 at 11:34 a.m., Resident 58 was observed from the hall grimacing, squirming, kicking her legs back and forth, coughing and gagging, still calling out, "I need to throw up," and "water, water, water." On 5/15/19 at 11:40 a.m., LPN 25 was asked to observe Resident 58. LPN 25 walked into the room, without knocking, and asked, "what do you want?" Resident 58 called out for "water." LPN 25 left the room. On 5/15/19 at 11:48 a.m., without closing the Resident's door, or pulling her privacy curtain, LPN 25 was observed as she changed Resident 58's tube feeding. She stopped the hanging tube feed, disconnected it, and hung the next bottle. At this time, Resident 78 passed by Resident 58's door. He stopped and looked into the room. LPN 25 stepped around Resident 78 to re-enter the room with a stethoscope. She pulled Resident 58's gown open, which exposed her brief, and began an assessment of Resident 58 in plain view of Resident 78.		care by nursing, staff to knock upon entering room. Resident 12 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: All residents have the potential to be affected by this alleged practice. The Director of Nursing/designee will educate on resident rights including, knocking prior to entering a room, pulling curtains while providing care, and not completing assessments in common areas. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The Director of Nursing or designee will educate on the following: 1.Nursing staff on resident rights including knocking on doors prior to entering, pulling curtains while providing care, and not completing assessments in common areas. 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.Observations of staff knocking	

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	During an interview on 5/17/19 at 9:08 a.m., the Director of Nursing (DON) indicated, the nurse should have pulled Resident 58's privacy curtain or closed her door before performing an assessment, in order to protect the Resident 58's privacy and dignity. On 5/17/19 at 10:00 a.m., Regional Clinical Consultant 8 provided a copy of current facility policy titled, "Resident Rights" dated, 8/11/17. The policy indicated, "...the purpose of this policy is to guide employees in the general principles of dignity and respect of caring for residents... care for residents will be provided in a safe respectful manner that includes care in a private setting... when providing care, staff will: knock before entering a room... speak respectfully to residents...have their privacy respected when treatment, medication, or care is being administered including, door closed or privacy curtain pulled...." 2. On 05/13/19 at 12:15 p.m., during a dining observation, in the Main Dining Room, Resident 12 was observed sitting at the dining table, in her wheel chair. Her eyes were closed and she was leaning to the right. The Hospice Nurse entered the Dining Room carrying a messenger type bag. She placed the bag on an empty chair, at an adjacent table. She took out a smaller zipped bag and laid it on the dining table, next to resident 12's drink. The nurse opened the zippered bag, and took out a blood pressure cuff, and pulse oximeter (used for measuring oxygen in the blood), and laid them on the table. She checked Resident 12's blood pressure, and then placed the pulse oximeter on the resident's finger. While she stood next to the resident, she did not speak to her. The Hospice Nurse was texting on her phone. She laid her palm		on doors 5 times weekly x 2 weeks, weekly x4 weeks and monthly x4 months. 2.Observations of curtains being pulled 5 times weekly x2 weeks, weekly x4 weeks and monthly x4 months. 3.Observations of assessments being completed in private patient care areas 5 times weekly x2 weeks, weekly x4 weeks and monthly x4 months. 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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	on the resident's head then took out a temporal thermometer and checked the resident's temperature. The Hospice Nurse then called out to RN 27, 2 tables away, "Hey do you have her today (pointing to the resident)? Is she (made a circle motion with her right index finger beside her right ear?" RN 27 grimaced and nodded in agreement. On 05/13/19 at 12:22 p.m., the Hospice Nurse left the dining room. She left her supplies on the dining table. The pulse pulse oximeter remained on Resident 12's finger. An unidentified Certified Nurse Aid (CNA) approached Resident 12 and looked at the pulse oximeter on her left hand, and bag of supplies open on the table. She then continued to serve lunch to residents in the dining room. On 05/13/19 at 12:32 p.m., the Hospice Nurse returned to the dining room. She was carrying a portable oxygen cylinder. She placed oxygen tubing in Resident 12's nose and hung the tank on the back of her wheel chair. She did not explain what she was doing to the resident. The Hospice Nurse then gathered her supplies and left the dining room. On 05/13/19 at 12:35 p.m., during an interview, the Hospice Nurse indicated the resident's daughter had called her, and told her Resident 12 was sick. Her oxygen saturation was low when the Hospice Nurse checked it. It was 79% (normal range is greater than 92%) . There was already an order for oxygen as needed and she needed an order for an antibiotic based on her assessment. She should not have done an assessment in the dining room.			

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	The resident should have been taken to her room, and returned to the dining room for her meal. On 05/16/19 at 2:50 p.m., Clinical Consultant 7 provided a current policy, dated 08/11/17, titled "Resident Rights". This policy indicated "...To have their privacy respected when treatment, medication, or care is being administered ... including, door closed or privacy curtain drawn, not have treatment, medication or care performed in common areas such as hallways, dinning rooms ...." 3.1-3(a)			
F 0576 SS=C Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the			

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	facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law.			
	Based on interview and record review, the facility failed to ensure resident mail delivery was completed every Saturday. This deficient practice had the potential to effect 69 of 69 residents residing in the building. Findings include: On 5/17/19 at 9:38 a.m., during a resident council meeting, Resident 1 indicated sometimes the residents did not get their mail delivered on Saturday. Two unidentified residents nodded in agreement. On 5/17/19 at 10:27 a.m., the Business Office Manager indicated on the weekends, a manager on duty would have distributed the resident mail, and placed the business office mail in the locked reception area. On 5/17/19 on 10:32 a.m., the Assistant Business	F 0576	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** All residents will receive mail on Saturdays. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: All residents have the potential to be affected by the alleged deficient practice. Activities staff/Managers on Duty will pass resident mail on Saturdays. **Measures put in place and systemic changes made to**	06/14/2019

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	Office Manager, and part-time receptionist indicated on Monday mornings there was resident and business office mail in the locked reception area. On 5/17/19 at 10:35 a.m., the Executive Director indicated the Activity Director or Manager would have delivered the mail on Saturdays. A current policy, titled, "Resident Rights," dated 8/11/17, was provided by Regional Clinical Consultant 7, on 5/16/19 at 3:36 p.m. A review of this policy indicated the resident had the right to, " ...have privacy in sending and getting mail and email ...." 3.1-3(s)(1)		**ensure the alleged deficient practice does not recur:** The Executive Director or designee will in-service the Activities staff/Managers on Duty on: 1.Resident Rights/Mail delivery **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the Executive Director/Designee 1.5 residents will be interviewed weekly x 4 weeks and monthly x 4 months to ensure residents receiving personal mail on Saturdays. 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	
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview, and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessments for 4 of 8 residents reviewed for Pre-Admission Screen and Resident Review	F 0641	**Corrective actions accomplished for those residents found to be affected by the alleged deficient**	06/14/2019

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(Residents 5, 38, 46, and 17). The facility failed to accurately code the MDS Assessments for 1 of 5 residents reviewed for pressure ulcers (Resident 52) and 1 of 2 residents reviewed for Activities of Daily Living (Resident 19).

Findings include:

1. On 05/16/19 at 09:56 a.m., the medical record for Resident 5 was reviewed. His diagnoses included, but was not limited to, bipolar disorder (a mental illness).

The annual comprehensive Minimum Data Set (MDS) assessment, dated 11/23/18, indicated Resident 5 did not have a level II Pre-Admission Screen and Resident Review (PASRR) Mental Health Assessment.

Resident 5 did have a PASRR level II in the medical record, dated 10/10/2018. This assessment indicated Resident 5 was mentally ill.

On 05/17/19 at 09:15 a.m., during an interview, the Licensed Practical Nurse 6, Resident Assessment Coordinator (RAC), indicated the RAC did not code the MDS Assessment for PASRR. Social Services provided the PASRR information for coding, on that section.

On 05/17/19 at 11:56 a.m., during an interview, the Social Service Director indicated she did not do MDS coding. If the MDS Coordinators had questions about a PASRR they would call and ask her, but they did the coding.

2. On 05/16/19 at 10:09 a.m., the medical record for Resident 38 was reviewed. His diagnoses included, but was not limited to, bipolar disorder, current episode manic severe with psychotic

practice:

MDS assessments for residents 5, 38, 46, 17, 52 and 19 were modified to reflect accurate assessments.

Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken:
Audit of most current MDS assessments to be completed on all residents to ensure accuracy of ADL's, pressure ulcers, and pre-admission screening and resident review by resident assessment coordinator. Any inaccuracies identified will be modified.

Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:
The regional resident care coordinator will educate the resident assessment coordinator on MDS responsibilities with emphasis on accuracy when completing resident assessments.

How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:
The following audits will be conducted by the resident assessment coordinator:

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	features, bipolar disorder, and schizophrenia (mental illness). The admission comprehensive MDS assessment, dated 11/16/18, indicated Resident 38 did not have a level II Pre-Admission Screen and Resident Review (PASRR) Mental Health Assessment. Resident 38 did have a PASRR level II in the medical record, dated 10/23/2018. This assessment indicated Resident 38 was mentally ill. On 05/17/19 at 09:15 a.m., during an interview, the Licensed Practical Nurse 6, Resident Assessment Coordinator (RAC), indicated the RAC did not code the MDS Assessment for PASRR. Social Services provided the PASRR information for coding, on that section. On 05/17/19 at 11:56 a.m., during an interview, the Social Service Director indicated she did not do MDS coding. If the MDS Coordinators had questions about a PASSAR they would call and ask her, but they did the coding. 3. On 05/15/19 at 09:47 a.m., the medical record for Resident 46 was reviewed. His diagnoses included, but was not limited to, bipolar disorder (a mental illness). The annual comprehensive MDS assessment, dated 07/14/18, indicated Resident 46 did not have a level II PASRR Mental Health Assessment. Resident 46 did have a PASRR level II in the medical record, dated 07/19/2017. This assessment indicated Resident 46 was mentally ill. On 05/17/19 at 08:56 a.m., during an interview, Registered Nurse 7, Resident Assessment		1.5 residents MDS assessments will be reviewed for accuracy 5 times per week x2 weeks, weekly x 4 weeks and monthly x 4 months to ensure accuracy of assessments. 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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	Coordinator (RAC), indicated Resident 46's MDS Assessment was coded wrong. 4. Record review was completed for Resident 17 on 05/15/19 at 11:33 a.m. The record indicated, the resident was originally admitted to the facility on 1/17/19, and most recently re-admitted on 4/26/19, with diagnoses to include, but were not limited to: major depressive disorder. Review of Physician's orders, for Resident 17 indicated: a. On 4/27/19 Trazodone HCI (antidepressant) tablet 50 milligram (mg), "give 50 mg by mouth at bedtime for antidepressants" b. On 5/2/19 "Monitor behaviors (antidepressant) 1. withdrawn 2. restlessness 3. tearfulness 4. poor intake. Non-pharmacological intervention 1. reassurance 2. encourage activities 3. redirection 4. assess for pain every shift for behaviors related to other specified depressive episodes ..." c. 5/2/19 "Complete behavior progress note, if resident has behaviors during your shift." Review of Admission Minimum Data Set (MDS), dated 5/3/19, indicated, Resident 17 did not have a level II Pre-Admission Screen and PASRR. The resident had the ability to make himself understood and to understand others. Brief Interview for Mental Status (BIMS) score 15 indicated, no cognitive impairment. No signs or symptoms of delirium, no behaviors, rejection of care, or wandering. Resident 17 medical record had documentation to indicate, on 3/31/19 a PASRR level II was completed, to indicate he had mental illness, but did not require special services. 5. On 05/13/19 at 12:09 p.m., the medical record for			

Resident 52 was reviewed. A Skin Assessment, on 4/22/19, indicated new pressure (wound) identified, house acquired, left thigh rear. All further weekly skin assessments referred to that area as non-pressure. It was documented as healed on 05/07/19.

The quarterly MDS assessment, dated 04/22/19, indicated pressure, unhealed, one area, stage two (open wound).

On 05/16/19 at 02:50 p.m., during an interview, Clinical Consultant 7 indicated Resident 52's MDS Assessment was coded wrong for pressure, she never had pressure, it was an abrasion.
6. On 5/13/19 at 10:36 a.m., Resident 19 was observed lying in bed, and a therapist was at beside who indicated, he was in the process of a swallowing study. Bilateral upper extremity contracture's observed, the resident did not verbally acknowledge a greeting.

On 5/16/19 at 9:59 a.m., Resident 19 was observed to be awake, the head of his bed was elevated, and his eyes were focused on the television. The resident would follow movement when someone was in the room, but did not respond verbally. There was a pillow between the quarter rail and resident, and a pillow down the length of the right leg, both to prop the resident on his right side. A pillow case was observed rolled and in his right hand, and a wash cloth rolled and in his left hand.

Record review was completed on Resident 19 on 05/15/19 at 9:20 a.m. The record indicated, the resident was admitted on 3/13/19 with diagnoses to include, but were not limited to: traumatic subdural hemorrhage with loss of consciousness of unspecified duration, anoxic brain damage, and stress fracture of the right femur. There was no

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	diagnosis regarding the upper and lower body contracture's. Review of Admission MDS, dated 3/22/19, indicated, Resident 19 had no speech, rarely/never made himself understood or understood others. Unable to complete interview for cognitive status, short and long term memory ok, cognitive skills for decision making severely impaired. Extensive assistance of 2 or more people for bed mobility, dressing, and eating. Limited assistance of 1 person for transfers. Walking in the corridor, room, and locomotion on and off the unit did not occur. Total dependence of 2 or more people for toilet use, personal hygiene, and the bathing activity. Mobility devices include a wheelchair. Occasionally incontinent of bladder, frequently incontinent of bowel. Special treatments included, oxygen, suctioning, trach care both before and as a resident. The MDS was observed to have incorrect documentation regarding the resident's short and long term mental status, and his mobility status. On 5/16/19 at 1:57 p.m., the Director of Nursing (DON) indicated, when Resident 19 was admitted to the facility, he could not talk, had minimal movement of his extremities, and was total care for all Activities of Daily Living (ADL's) per staff. He would make facial expressions, but would not have been able to verbalize for staff to evaluate his short or long term memory. The resident still had a trach unless it was recently removed. The resident was admitted with contracture's. On 5/16/19 at 2:25 p.m., RAC RN 6 indicated, MDS coding could be inaccurate if the CNA's documented inaccurately. The 2 RAC nurses had not questioned the floor staff or family for additional information for accuracy, and therefore			

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	MDS documentation for Resident 19 was inaccurate. On 5/17/19 at 9:28 a.m., Regional Director of Clinical Operations 8 indicated to her knowledge, each person signing completion on the MDS was responsible to assure accuracy of the MDS, there was no outside oversight for MDS documentation and accuracy. On 5/17/19 at 11:16 a.m., Regional Director of Clinical Operations 7 provided a policy, titled, "MDS Responsibilities", revised 2/26/19. 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 interdisciplinary assessment shall be completed for all residents utilizing the Resident Assessment Instrument [RAI] - Minimum data set 3.0 [MDS] based upon oral or written communication, resident, family interview and assessments provided by the IDT team members ...Each individual who completes a portion of the assessment [RAI] must certify the accuracy of that portion by signing and dating in the appropriate location in Section Z, including their job title and sections of MDS they completed...."			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the			

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	recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.			
	Based on interview, and record review, the facility failed to obtain a Pre-Admission Assessment and Resident Review (PASRR) Level II assessment for a resident with a new mental illness diagnosis (Resident 40) for 1 of 8 residents reviewed for PASRR. Findings include: On 05/15/19 at 10:50 a.m., the medical record of Resident 40 was reviewed. She was admitted to the facility on 10/14/15. Her diagnoses included, but was not limited to schizophrenia (a mental illness), dated 08/16/17. A Level I Pre-Admission and Resident Review (PASRR) was dated 10/13/15, and indicated new admission. An annual comprehensive Minimum Data Set assessment, dated 05/30/18, indicated Resident 40 did not have a PASRR Level II assessment. On 05/17/19 at 11:56 a.m., during an interview, the Social Service Director indicated Resident 40 did not have a Level II PASRR assessment. She received a diagnosis of schizophrenia before the Social Service Director came to work for the facility. She was not aware of a new diagnosis in	F 0644	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident 40 was not harmed by deficient practice. A level II was obtained for resident 40. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: An audit was conducted of all residents and any found to have a diagnosis requiring a level 2 were referred to the appropriate parties and a level 2 will be obtained. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Executive Director or designee will in-service the Social Services on: 1.Pre-admission screening and	06/14/2019

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	2017, for Resident 40. The Resident should have had an evaluation and assessment completed at that time. On 05/16/19 at 2:50 p.m., Clinical Consultant 7 provided a current policy, dated 2011, titled "Clinical Record Guidelines." This policy indicated "...Social Service Records: Social history and assessment will be completed within 14 days after admission. Progress notes indicating implementation of methods to respond to identified needs and the resident's progress will be written, as needed, but at least quarterly, to indicate changes in resident's needs. If social services are provided by an outside resource, a record is maintained of each referral to this source...."		resident review. 2.The procedure for residents that are newly diagnosed with a mental illness. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the Executive Director/Designee 1. Audits of new admissions to ensure Level 2 in place if required 5 days per week x 2 weeks, weekly x4 weeks and monthly x4 months. 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	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The			

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	comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans for 2 residents (Residents 40 and 34) with a diagnosis of schizophrenia for 2 of 8 residents reviewed for Pre-Admission Screening Resident Review (PASRR), and a resident with diagnosis of	F 0656	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident 40, 34, and 20 care	06/14/2019

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	dementia for 1 of 1 residents reviewed for dementia care (Resident 20). Findings include: 1. On 05/15/19 at 10:50 a.m., the medical record of Resident 40 was reviewed. She was admitted to the facility on 10/14/15. Her diagnoses included, but was not limited to, schizophrenia (a mental illness), dated 08/16/17. No plan of care for a diagnosis of schizophrenia was documented. On 05/17/19 at 11:56 a.m., during an interview, the Social Service Director indicated Resident 40 had received a diagnosis of schizophrenia before the Social Service Director came to work for the facility. She was not aware of a new diagnosis in 2017, for Resident 40. The Resident should have had an evaluation and assessment completed at that time. On 05/17/19 at 09:25 a.m., during an interview, Clinical Consultant 8 indicated the IDT (interdisciplinary team) did updates to the care plan. Resident 40 should have had a care plan implemented for a new diagnosis of schizophrenia. 2. On 5/15/19 at 10:12 a.m., Resident 34's diagnosis included, but were not limited to, schizophrenia, repeated falls, diabetes mellitus without complications, and absolute glaucoma. On 5/15/19 at 10:15 a.m., Resident 34's comprehensive care plans were reviewed. No schizophrenia care plan was found. On 5/17/19 at 11:07 a.m., Regional Clinical Consultant (RCC) 8 indicated the facility did not have a comprehensive care plan for Resident 34's		plans have been updated to reflect required diagnoses **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: An audit of resident careplans was conducted to ensure an accurate plan of care is reflected including pertinent diagnosis. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The staff development coordinator will in-service the licensed nurses on: 1.Plan of Care Overview with emphasis on adding pertinent diagnosis. The regional resident care coordinator will in-service the resident assessment coordinators on: 1.Plan of Care Overview with emphasis on adding pertinent diagnosis. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the DON/designee: 1.5 residents care plans will be reviewed for accuracy 5 times per week x 2 weeks, weekly x4 weeks	

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	schizophrenia (long term mental disorder of a type involving a breakdown in the relations between thought, emotion, and behavior) diagnosis. She should have had an individualize plan of care for schizophrenia. On 5/17/19 at 1:44 p.m., Resident Assessment Coordinator Licensed Practical Nurse (RAC LPN) indicated the 4/16/19 Minimum Data Set (MDS), under active diagnosis, indicated Resident 34 had schizophrenia. 3. On 5/16/19 at 9:17 a.m., a comprehensive medical record review was completed for Resident 20. A most recent comprehensive assessment was a quarterly Minimum Data Set (MDS) assessment, dated 3/16/19. The MDS indicated Resident 20 had active diagnoses to include but were not limited to: Non-Alzheimer's dementia Resident 20's comprehensive care plan was reviewed, but did not include a care plan addressing her needs, approaches, and/or goals on how to care for and live with her diagnosis of Dementia. During an interview with the Director of Nursing, (DON), on 5/17/19 at 9:08 a.m., she indicated, residents who have a diagnosis of dementia should have care plans addressing needs, either one specific all-inclusive care plan, or addressed throughout the entirety of the comprehensive plan of care. A current policy, titled, "Plan of Care Overview," dated 7/26/18, was provided by RCC 8 on 5/17/19 at 10:20 a.m. A reviewed of the policy indicated, " ...The facility will provide an RN (Registered Nurse) assessment of the resident as an on-going,		and monthly x4 months. . 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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	periodic review that provided the foundation for resident focused care and the care planning process." 3.1-35(a) 3.1-35(b)(1)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility	F 0657	**Corrective actions accomplished for those**	06/14/2019

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	failed to ensure care plan meetings were held in a timely manner for 1 resident (Resident 7), and care plans were revised in a timely manner for 2 residents (Residents 52 and 37) for 3 of 27 residents reviewed for care plans. Findings include: 1. During a family interview, on 5/13/19 at 2:53 p.m., Resident 7's family remember indicated she had been to one care plan meeting. If any other care plan meetings were held, she was not aware of them. Resident 7 admitted to the facility on 10/30/18. On 5/17/19 at 2:03 p.m., Regional Clinical Consultant 7 provided written documentation of an invitation to Resident 7's care plan meeting held on 11/27/18. On 5/17/19 at 3:38 p.m., Regional Clinical Consultant 7 indicated the Director of Social Services usually did a verbal invitation for care plan meetings. On 5/17/19 at 4:06 p.m., Regional Clinical Consultant 7 indicated there were no notes for any other care plan meetings being held for Resident 7. 2. On 05/14/19 at 01:42 p.m., the medical record for Resident 52 was reviewed. Skin Assessments indicated, several non-pressure open areas to the skin. These included, left thigh rear identified 4/19/19, a right thigh rear identified 04/22/19, and gluteal fold healed 05/07/19. A care plan initiated on 04/19/19, with a target date of 07/15/19, indicated Resident 52 had a potential for an alteration in skin integrity. A Progress Note, dated 04/29/19, indicated		**residents found to be affected by the alleged deficient practice:** Resident 7 was not harmed by the deficient practice. The family of resident 7 has a scheduled careplan and will continue to be invited no less than quarterly for careplan meeting. Resident 52 care plan updated as needed. Resident 37 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**: An audit was conducted and any resident residing in the facility that has not been invited to or had a careplan meeting has had one scheduled according to their MDS schedule. Residents with skin alterations will have their care plan reviewed to ensure accuracy, and updated as needed. Residents who have sustained falls within last 30 days will have care plans reviewed for accuracy. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The staff development coordinator will in-service the nursing staff on: 1.Careplan revision 2.Fall policy/procedure	

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	"Resident seen by Dr. (Name) this morning. Wounds to right and left thighs assessed, and new order received: Calcium alginate (a treatment) to wounds, cover with ABD (a type of dressing) pads, and secure with tegaderm (a clear adhesive) film. Resident informed of new order. Writer completed dressing change as prescribed at 9 a.m." A Progress Note, dated 05/06/19, indicated "Resident was seen by wound MD (doctor) this morning. Left medial posterior upper leg abrasion is healed, Remaining two areas are improving. Order to continue with current treatment. Resident alert and understanding of continued tx (treatment) order." No plan of care for actual alteration in skin integrity was documented. On 05/17/19 at 09:25 a.m., during an interview, Clinical Consultant 8 indicated the IDT (interdisciplinary team) did updates to the care plan. Resident 52 should have had a care plan revision or update for open wounds on her skin. 3. During a random interview on 5/13/19 at 12:35 p.m., Resident 37 indicated, he had 3 falls since his admission while getting up to the bathroom, staff would not answer his call light times, so he would get up independently. Also indicated, he was a smoker of many years, and kept his smoking supplies in his bedside drawer so staff would not steal them. Record review was completed on Resident 37 on 5/15/19 at 11:33 a.m. The record indicated, the resident admitted to the facility with diagnoses, to include, but were not limited to: muscle weakness, end stage renal disease, dependence on renal		The executive director will inservice social services on: 1.Plan of Care overview with emphasis on invitations and revisions **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the DON/Designee 1.Audit of care plan invitations of 5 residents 5 times per week x 2 weeks, weekly x4 weeks, monthly x4 months. 2.Audit of fall documentation to include time of fall, details of fall and root cause of 5 falls per week x 2 weeks, weekly x 4 weeks, and monthly x4 months. 3.Audit of care plans for new actual skin alterations of 5 residents 5 times per week x2 weeks, weekly x 4 weeks, monthly x 4 months. 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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	dialysis, major depressive disorder, difficulty in walking, diabetic neuropathy, and other reduced mobility. Review of an assessment for Resident 37, titled, "Fall Follow Up", dated 4/11/19. The assessment indicated, the resident fell on 4/11/19, there was no time of the fall, or details of the root cause. Review of Resident 37's Progress notes indicated, on 4/27/2019 at 4:54 p.m., the resident was found sitting on the floor next to his bed. Review of Resident 37's Care Plans indicated, there were no care plans regarding the resident falls, or documentation to indicate the resident smoked cigarettes. On 5/17/19 at 11:16 a.m., Regional Director of Clinical Operations 8 provided a policy, titled, "Plan of Care Overview", revised 7/26/18. 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 the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences ...Resident/representative will have the right to participate in the development and implementation of his/her own POC [plan of care] ...The facility will: i. Provide an RN assessment of the resident as an on-going, periodic review that provides the foundation for resident focused care and the care planning process ...Review care plans quarterly and/or with significant changes in care ...Provide a			

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	summary of the baseline care plan to the resident and their representative ...schedule meetings to accommodate a resident's representative that may include conference calls, video conference sessions or live sessions ...Care plan documents are resident specific/resident focused and reflect resident/representative opportunities for participation and preferences ...Attendees will sign and date care plan meeting agendas/documents ..." On 5/17/19 at 3:30 p.m., Regional Directors of Operations 7 and 8 indicated, there was no facility policy for fall follow up. 3.1-35(a) 3.1-35(d)(2)(B) 3.1-35(e)			
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 professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on interview, and record review, the facility failed to ensure documentation and care plans were developed for a resident with drug overdose, and possible seizure activity for 1 of 1 residents reviewed for seizures (Resident 59). Findings include:	F 0684	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident 59 no longer resides in facility.	06/14/2019

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	During an interview, on 5/15/19 at 10:45 a.m., Resident 59 indicated recently he had received the wrong medication and was not feeling right. He believed he had a seizure. He had to have his roommate call 911, because no one would answer his call light. He was in the hospital for 8 days. On 5/14/19 at 3:40 p.m., Resident 59's record was reviewed. Diagnoses included, but were not limited to, epilepsy (neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions), hemiplegia (one side of the body paralysis), hemiparesis (one side of the body weakness), cerebral infarction (stroke), respiratory failure with hypoxia (lack of oxygen), cocaine abuse (illegal substance abuse), and post-traumatic stress syndrome (persistent mental and emotional stress occurring as a result of injury or severe psychological shock). On 5/15/19 at 8:48 a.m., Resident 59's risk for falls care plan indicated the resident was at risk related to epilepsy, and hemiplegia. An intervention was Resident 59 needed prompt response to all requests for assistance. This care plan was created on 4/3/19, and was revised on 4/3/19. No further revisions were completed for the risk for falls care plan. The nursing incident report, dated 4/19/19, indicated Resident 59 had an unwitnessed fall and a witnessed fall. The nursing incident report indicated Resident 59, "was sleeping when I did my rounds raound [sic] 4pm. At 6pm I went to his room to give him medication and the CNA was also entering the room to bring dinner. He sat on the side of the bed and took the medication....he then began to point at the food and get angry. I offered the alternative. Another resident went in		**Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: Residents who have sustained falls within last 30 days will have documentation and care plans reviewed for accuracy. Residents with a known history of substance abuse will have care plans reviewed to ensure accuracy and will be updated as needed. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The staff development coordinator will inservice nursing staff on the following: 1.Documentation guidelines 2.Fall procedure and policy 3.Careplan revision **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the DON/Designee: 1.Documentation of falls on 5 residents 5 times per week for 2 weeks, weekly for 4 weeks, and monthly for 4 months. 2.Care plans for residents sustaining falls 5 times per week for 2 weeks, weekly for 4 weeks and monthly for 4 months.	

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	155664	A. BUILDING 00 B. WING	05/17/2019

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	his room to visit and came out and told me he had thrown his [sic] self on the floor. Vitals were taken all WNL [within normal limits] and several staff assisted to get him off the floor. Once in his chair he threw his [sic] self on the floor again. Staff attempted to put him in his chair again, resident was resisting. ED (Executive Director) was contacted, NP (Nurse Practitioner) was notified, attempted next of kin voicemail was full. Resident had another resident call 911 for him. They took resident out of building via stretcher." During an interview, on 5/17/19 at 3:24 p.m., RCC 8 indicated Resident 59 had consumed cocaine while on leave of absence. He was resistive to assistance, and wouldn't allow the staff to help him to the chair, so the staff took his vital signs. The resident was having behaviors. Since, he was resistant, no nursing assessment was done. There should have been a care plan for the behavior of throwing himself to the floor, and the history of illegal substance abuses that contributed to his behaviors. The hospital record indicated the resident was positive for cocaine. But, the nurse should have done a complete assessment after the falls, and it should have been documented more clearly. A hospital discharge summary, dated 4/26/19, was provided by RCC 7, on 5/17/19 at 3:08 p.m. A review of Resident 59's discharge summary indicated, " ...The patient was found to have epileptiform (pertaining to epilepsy or resembling epilepsy) discharges on his EEG (test to record brain wave patterns). During this admission, he was started on lacosamide (anti-epileptic medication). He did not have any subsequent seizure after initiation of this. Initially, he was intubated (a tube placed in the trachea for breathing) for airway protection. He was able to		3.New residents care plans who admit with a substance abuse history 5 times per week for 2 weeks, weekly for 4 weeks and monthly for 4 months. 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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	be successfully extubated after the first 2 days of this admission ...." Resident 59's risk fall care plan was not updated due to his falls on 4/19/19.There were no care plans found for the resident's diagnosis of epilepsy, his behaviors, or his history of illegal substance abuse. He did not have a fall care plan, only a risk for falls care plan. On 5/16/19 at 11:06 a.m., Regional Clinical Consultant (RCC) 7 indicated there were no Inter-Disciplinary Team (IDT) (administrative team to review resident care and needs) notes for Resident 59's falls on 4/19/19, the only nursing assessment was vital signs. On 5/17/19 at 11:15 a.m., the Executive Director indicated the resident did not report to her anything about receiving the wrong medications, having a seizure, or no staff answering his call light. On 5/17/19 at 11:16 a.m., RCC 8 indicated nursing assessments were based on resident injuries. Resident 59 goes on leaves-on-absence (LOA) and had a history of substance abuse. The hospital assessment indicated he was positive for cocaine. A document, titled, "Nurse's Notes Guidelines," dated 3/2011, indicated for ill, incident, or change in condition, " ...There are many event that occur in a resident's life that require specific information to be documented in the nurses' notes ...date and time, nursing observations, location and description, if an incident, statement of witnesses (for incident), nursing actions taken, persons notified, including physician and /or family members, and their instructions for care, signs			

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	observed, symptoms expressed by resident, vital signs and a subsequent follow-up entry until the situation is stable or resolved ...." A current policy, titled, "Plan of Care Overview," dated 7/26/19, was provided by RCC 8 on 5/17/19 at 10:20 a.m. A review of 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 facility will provide an [sic] RN (Registered Nurse) assessment of the resident as an on-going, periodic review that provides the foundation for resident focused care and the care planning process ...The "MDS (Minimum Data Set) Coordinator" will oversee and coordinate the care team and PoC (Plan of Care) ...Care plan documents are resident specific/resident focused...." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			

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	Based on observation, interview, and record review, the facility failed to implement precautions and interventions to prevent a pressure ulcer from re-opening for 1 of 5 residents reviewed for pressure ulcers (Resident 20). Findings include: On 5/13/19 at 11:08 a.m., Resident 20 was observed lying in bed with her eyes closed. Her sheets were kicked up so that her bare feet were visible. Her left ankle was pulled up to her right knee, and positioned down, pressing into the mattress. No bandage/treatment, or sock was observed in place. During an interview with Resident 20 on 5/14/19 at 9:41 a.m., she indicated there was a sore on her foot, that had healed, but was back again. She pulled the sheet off her leg so that her ankle could be seen. Her left foot was pulled to the inside of her right thigh, so that her ankle was down, and pressed into the bare mattress. No sock, treatment or bandage was observed in place. Resident 20 indicated sometimes they put a treatment on it, sometimes they did not. On 5/14/19 at 11:14 a.m., Resident 20 was observed lying in bed in the same position positioned as above, and indicated there was still no treatment in place for her wound. On 5/14/19 at 1:43 p.m., Resident 20 was observed lying in bed, in the same position, ankle down, pressed into the mattress, with no treatment observed in place. On 5/15/19 at 9:05 a.m., Resident 20 was observed sitting up in bed having finished breakfast. Her	F 0686	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident 20 was not harmed. Pressure relieving device has been implemented. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: All residents are at risk. All residents have had a Braden assessment completed to identify residents at risk for pressure ulcers and plan of care revised to include interventions for pressure ulcer prevention. An audit has been completed to validate all treatments have been completed and dressings secured. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The DON/designee will in-service the nursing staff on: 1.Skin Care and Wound Management to include prevention, plan of care, following physician's orders for treatments. **How the corrective measures will be monitored to ensure the alleged deficient practice does**	06/14/2019

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	left ankle was observed bare, and pressed against the mattress. Resident 20 indicated there was no bandage on her ankle. On 5/15/19 at 2:37 p.m., Resident 20 was observed sitting up in bed. Her left ankle was observed and found to have a square foam pad in place, but her ankle was still down, and pressed into the mattress. During an interview with CNA 29 on 5/16/19 at 9:32 a.m., she indicated Resident 20 did have a pressure ulcer on her ankle, and her ankle was supposed to be off the mattress. With Resident 20's permission, CNA 29 observed the residents ankle, down and pressed into the mattress. CNA 29 indicated even with the foam in place for protection, her ankle should be off the mattress to relieve the pressure from the area. CNA 29 indicated Resident 20 had a tendency to pull her leg up and keep her ankle pressed into the mattress, and it was hard to check her as often as needed for repositioning because of the workload, and having too many residents to get to. On 5/17/19 at 10:00 a.m., a wound treatment procedure for Resident 20's ankle was provided by the Wound Care Coordinator (WCC). Upon entering the room, Resident 20's feet were off-loaded from the mattress using a large blue cushion, that had not been observed in the Resident's room until that time. The Wound Care Coordinator removed a soiled bandage, cleansed the wound with normal saline and visualized the wound. She indicated the wound was a stage III (Full-thickness loss of skin, in which fat is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) pressure ulcer, with a small amount of Serosanguineous drainage (a fluid mixture of both blood, and the		**not recur:** The following audits will be conducted by the DON/Designee: 1.5 residents daily for 5 days a week will be observed to validate prevention interventions are in place and treatments have been completed per physician's orders, then three residents daily three times a week, then two residents daily twice a week. 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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	liquid part of blood, serum), and 75% granulation (new skin growth), with a depth of 0.1 cm (centimeters). The wound was observed to be approximately the size of a quarter, with white, circular edges, defined depth, and a small amount of yellowish/clear fluid. During an interview with the WCC on 5/17/19 at 10:05 a.m., she indicated the wound had been closed, but recently reopened just that week. She though the wound reopened due to the Resident's tendency to pull her leg up, but the CNAs knew to keep that heel floated, and this [large blue wedge pillow] was supposed to be used at all times. [Resident 20] was supposed to be checked on every shift, at least every two hours for incontinent care. On 5/16/19 at 9:17 a.m., a medical record review was completed for Resident 20. Resident 20 had physician orders to include, but were not limited to: "...Cleanse left ankle ulcer; pat dry. Apply dermacol; cover with foam. Change Monday, Wednesday, and Friday and as needed for displacement...." Resident 20's comprehensive care plan was reviewed, and included but were not limited to: A care plan that addressed her as being at risk for skin issues, but did not indicated a history of pressure ulcers, other current pressure area. A second care plan that addressed her need for assistance with ADLs (activities of daily living) which indicated her need for staff assistance for bed mobility including turning and repositioning. A weekly skin assessment, dated 5/6/19, indicated the wound had briefly healed, but re-opened on 5/13/19, and there was a turning and repositioning program in place.			

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	During an interview with the DON on 5/17/19 at 9:08 a.m., she indicated staff should be following orders, and interventions to help prevent pressure areas from developing or re-opening. On 5/17/19 at 10:00 a.m., a copy of current facility policy was provided by Regional Clinical Consultant 8. The policy was titled, "Skin Care & Wound Management Overview" date, 7/10/2016., and indicated, "... a pressure ulcer is defined as a localized injury to skin and/or underlying tissue usually over a bony prominence, as a result of pressure of pressure in combination with shear and/or friction. The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing found. The interdisciplinary team works with the resident/patient and/or family/responsible party to identify and implement interventions to prevent and treat potential skin integrity issues...identity diagnosis or conditions to place the resident/patient at risk for pressure ulcer development. Risk factors may include but are not limited to: ... healed pressure ulcer... develop a care plan with individualized interventions to address risk factors..." 3.1-40(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and			

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	§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on observation, interview and record review, the facility failed to ensure a resident who required range of motion and splint services received appropriate interventions to prevent the possibility of reduced range of motion and prevent contractures, (Resident 18) for 1 of 2 residents reviewed for positioning. Findings include: On 5/13/19 at 10:35 a.m., Resident 18 was initially observed siting up in her bed. She was unable to verbally communicate but answered simple yes or no questions. Resident 18 was observed using her left arm to adjust her blanket, but her right arm remained flaccid, as she was unable to move it. Her right hand was observed curled into a soft fist. On 5/14/19 at 10:15 a.m., Resident 18 was being visited by a family member, and with the Resident's permission, an interview was conducted with the family member. The family member indicated, Resident 18 had suffered a stroke, and sense then she had been paralyzed on her right side. Resident 18 was supposed to have a splint on her right hand at least 4 to 6 hours a day to prevent a contracture, but the staff never	F 0688	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident 18 was not harmed. Resident 18 has a brace and restorative plan for ROM and splint application. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: All residents receiving restorative services are at risk. An audit will be completed to validate residents with an order for a splint have a splint, MD orders, schedule of application, and care plan. An audit will be completed to identify residents that need a restorative program. C.N.A.s will be designated to complete the restorative programs in the event the restorative positions are vacant.	06/14/2019

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	put it on, and the few times it had been put on, it was incorrectly worn. The family member pulled a blue brace/splint from the resident's bedside dresser and indicated, that was where it always was. The family member indicated, Resident 18 was also supposed to have range of motion exercises performed for her hand, but that staff never did that either. On 5/14/19 at 1:31 p.m., CNA 30 was observed as she assisted Resident 18 with a lunch tray in the room. CNA 30 indicated she did not know if Resident 18 was supposed to have a splint or not. On 5/15/19 at 8:59 a.m., Resident 18 was observed, no splint or brace was observed in place. On 5/16/19 at 9:37 a.m., Resident 18 was observed, no splint or brace was observed in place. During an interview with the Resident Assessment Coordinator/Registered Nurse 6 (RAC/RN 6), on 5/16/19 at 11:21 a.m., she indicated the facilities two Restorative aids quit two weeks ago. Since then, the CNAs had been instructed to pick up the Restorative Aid duties and were supposed to be assisting residents with splint/braces, and range of motion exercises. RAC/RN 6 indicated, the CNAs should know who was on restorative, and there were instructed to basically just to do range of motion for those who could not do it themselves, and try to work it in when they were doing their ADL care with residents. RAC/RN 6 indicated, regardless of staffing residents shortages, residents should be receiving range of motion and splint services in accordance to their plan of care. During an interview with CNAs 29, and 31, on 5/16/19 at 11:24 a.m., they indicated they were told		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The DON/designee will in-service the nursing staff on: 1.The Restorative program to include how to identify residents receiving a restorative program. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the DON/Designee 1.5 residents restorative programs to be reviewed 5 times per week x 2 weeks, weekly x4 weeks and monthly x 3 months.. 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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a couple weeks ago to pick up and help out with range of motion. They were not provided a list of residents who required the services, they were not provided training, and they were not able to perform range of motion services like they were supposed to because they already had too much to do.

During an interview with CNAs 30 and 10, on 5/16/19 at 11:32 a.m., they also indicated range of motion services were not being provided as they should be, because the CNAs could not get to all the work they were already supposed to do before the Restorative Aids quit. They indicated they were not provided training, did not know who required range of motion services and were told that basically everyone on 200 needed range of motion and to fit it in where possible.

On 5/15/19 at 2:40 p.m., a comprehensive medical record review was completed for Resident 18.

Resident 18 had physician orders to include but were not limited to: "... nursing restorative: passive range of motion 6-7 times per week to right extremity to prevent contracture formation, and splint assistance 6-7 days per resting hand splint to right hand 4-6 hours per day.

A copy of the CNA assignment sheet was provided by Regional Clinical Consultant 8 on 5/17/19 at 10:00 a.m., which indicated the resident was supposed to receive range of motion services and splint assistance.

Resident 18 had comprehensive care plans to include but were not limited to: a care plan addressing her risk for contracture and impaired functional range of motion to her right extremity, and the care plan included interventions of range

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	of motion services and splint assistance. On 5/17/19 at 10:00 a.m., a copy of current facility policy was provided by Regional Clinical Consultant 8. The policy was titled, "Restorative Program" dated, 7/26/99, and indicated, "... the purpose of this policy is to provide direction and guidance to the clinical team to assess and implement a plan of action for resident-specific care to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable..." 3.1-42(a)(2)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure safe smoking practices were followed for 5 of 5 residents reviewed for safe smoking, by allowing residents to carry their own smoking materials, and smoke in places other than designated safe smoking areas (Residents 46, 28, 280, 17 and 37). Findings include: 1. On 05/13/19 at 11:15 a.m., during an observation and interview, Resident 46 indicated he signed	F 0689	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Residents 46, 28, 280, 17, 37 educated on smoking policy and to include returning smoking paraphernalia to nursing staff. **Identification of other residents**	06/14/2019

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EAGLE CREEK HEALTHCARE CENTER	4102 SHORE DR INDIANAPOLIS, IN 46254

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	himself out and went outside, off the property, where he smoked. He had smoking materials in his pocket (cigarettes and a lighter). On 05/13/19 at 11:40 a.m., Resident 46 was observed as he signed himself out in a binder, at the nurses' station. He exited out the front door of the facility, and proceeded across parking lot, off the property. On 05/14/19 at 08:27 a.m., Resident 46 was observed outside, in his wheel chair, beyond the parking lot (off the property). He was smoking. On 05/17/19 at 08:36 a.m., Resident 46 was observed outside smoking, adjacent to the front entrance, in the court yard without staff present. On 05/14/19 at 2:52 p.m., Resident 46's medical record was reviewed. A care plan goal for Resident 46 indicated, the resident would follow the policy and procedure for smoking. The interventions included, but were not limited to, Resident 46 was aware of the designated smoking areas, smoking times, and requirements for the storage of smoking materials. On 05/17/19 at 09:25 a.m., during an interview, Clinical Consultant 8 indicated, independent smokers were supposed to turn their smoking materials in to the staff, and request them each time they want to smoke. They should not be kept in their rooms, or on their person. 2. During an interview, on 5/13/19 at 10:00 a.m., in Resident 28's room, she picked up her purse from the over the bed table, opened, it and gave Resident 280 a cigarette. On 5/16/19 at 2:01 p.m., a review of Resident 28's smoking care plan indicated she had been		**having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: Residents who are smokers will be educated on smoking policy to include residents identified as independent smokers will be able to secure smoke materials. An audit will be completed to identify all residents wishing to smoke and the plan of care will be updated to include the smoking policy and interventions. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Executive Director or designee will in-service staff on: 1.Resident/Patient Smoking policy and securing smoking paraphernalia. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the Executive Director/Designee: 1. The IDT will complete room rounds 5 times a week for 30 days to validate smoking materials are secured, then three times a week for 30 days, then twice a week for 30 days. The results of the audit	

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	assessed as an independent smoker, would follow the facility smoking policy, was aware of the designated smoking areas, and the requirement for storage of smoking materials. 3. On 5/13/19 at 10:00 a.m., Resident 280 accepted a cigarette from Resident 28 and left her room, and entered the facility hallway. During an interview, on 5/16/19 at 1:50 p.m., Qualified Medical Aid (QMA) 19 indicated the facility and the residents should have been following the facility smoking policy, but there were defiant residents that didn't follow the smoking policy. The cigarettes and lighters were supposed to be locked up, but they were not always locked up. On 5/16/19 at 3:30 p.m., the Director of Nursing indicated the residents should not have cigarettes and lighters in their room because they should not be smoking in their rooms. 4. On 5/14/19 at 10:55 a.m., staff indicated Resident 17 displayed paranoid behavior to include, thinking staff were talking about him, turned off or refused his Total Parenteral Nutrition (TPN), does not comply with orders, and unable to always be redirect by staff. On 5/17/19 at 10:49 a.m., Resident 17 was observed walking around in the facility, and outside the front of the facility several times. Record review was completed for Resident 17 on 5/17/19 at 10:52 a.m. The record indicated, the resident was re-admitted on 4/26/19 with diagnoses to include, but were not limited to: nicotine dependence. Review of a Smoking Assessment, dated 5/6/19, indicated, Resident 17 smoked cigarettes, was		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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	aware of the risk with the use of nicotine, could light his own cigarettes, and care plan was updated to reflect use of cigarettes. Review of Resident 17's care plans, indicated, "1. Focus: [Resident] wishes to smoke and participates in assigned smoking times. Goal: [Resident] will smoke safely at designated area(s) at scheduled times through next review date. Interventions: Complete smoking assessment. Reassess [Resident] quarterly, annually, and with change of condition that affects the ability to smoke. Monitor [Resident's] safety during smoking. 2. 4/24/18, updated 8/16/18 Focus: Smoking: Resident has potential for injury due to smoking habit. Goal: Will be free from injury while smoking and will smoke in designated area. Interventions: Assess for safety awareness, smoking cessation, risk and benefits and education as needed. Monitor for compliance with smoking policy. Will have supervision while smoking ..." On 5/17/19 at 1:19 p.m., Resident 17 indicated, he was a smoker. He could go outside the back door and smoke at designated smoking times. If he wanted to smoke at times not designated, he could sign himself out and go up to the road off property. When he got cigarettes, he would get 2 packs at a time, 1 pack to go in the box at the nurse's station, and he would keep the other pack in his drawer at bedside. 5. During a random interview on 5/13/19 at 12:37 p.m., Resident 37 was observed siting at bedside in his wheel chair, a cell phone in his lap, and a key hanging from a chain around his neck. The resident indicated, he was a smoker of many years, and kept his smoking supplies in his bedside drawer so staff would not steal them.			

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On 5/16/19 at 9:05 a.m., Resident 37 was observed outside alone smoking along the side of the facility, near the designated smoking area.

On 5/17/19 at 9:15 a.m., Resident 37 was observed sitting in a wheel chair beside the facility in his wheel chair, near the designated smoking area.

On 5/17/19 at 1:17 p.m., Resident 37 indicated, he continued to store his smoking materials to include his cigarettes and lighter in his bedside stand, as he did not trust others to include staff not to steal them.

Record review was completed on Resident 37 on 5/15/19 at 11:33 a.m. The record indicated, the resident was admitted on 3/15/19, and had no documented diagnoses of nicotine dependence.

On 5/17/19 at 10:23 a.m., LPN 18 provided an assessment for Resident 37, titled, "Smoking Assessment", dated 5/2/19. The document indicated, the resident used cigarettes, was aware of the risk for use of nicotine, smoked 2-5 times daily, could light his own cigarettes, and the care plan was updated to reflect use of nicotine.

Review of the Baseline Care Plan, and care plans in the electronic medical record, indicated, Resident 37 had no documentation regarding smoking cigarettes.

On 5/17/19 at 9:29 a.m., Regional Director of Operations 8 indicated, Resident 37 was not supposed to have smoking materials locked in his room, they were to be turned in to the nurses on the unit for storage.

On 5/17/19 at 10:20 a.m., LPN 18 indicated,

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	residents that smoked had a smoking assessment in the electronic medical record (EMR), and all smoking materials were to be kept in the smoke box under the nurse's desk. On 5/17/19 at 10:23 a.m., LPN 13 indicated, all residents, to include Resident 37, were to leave their smoking materials in a smoke box that she demonstrated was under the nurse's desk. Residents could not keep smoking materials on their person. On 5/14/19 at 2:00 p.m., the Administrator provided a policy, titled, "Resident/Patient Smoking", revised 3/25/16. The policy indicated, "It is the policy of this facility to promote resident centered care by providing a safe smoking area for residents/patients that request to smoke and are capable of safe smoking behaviors either independently or with supervision unless the facility is designated non-smoking facility ...Residents will be assessed by the interdisciplinary team [IDT] and designated 1) independent or 2) supervised. Smoking cessation programs are available and encouraged. Procedure: 1. Assessment, observation and designation of independent or supervised smoker will be made by the IDT team for each resident/patient who requests to smoke in the facility. a. Complete the screen in the electronic medical record system. b. Smoking Assessments for those residents requesting to smoke will be completed or re-evaluated on i. admission, ii. quarterly, iii. any changes in clinical condition ...3. Based on IDT recommendations, the designation may be changed based on recent assessments by the team and will include, a. Documentation in the resident medical records including reasons for change, b. update care plan to reflect changes ...5. Smokers will be permitted to smoke only in			

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	designated smoking areas, a. For supervised smokers: smoking times will be posted by the facility ...8. Facility staff will: a. Secure smoking materials in a locked area when not in use by the resident/patient for both independent and supervised smokers ....All smoking materials will be maintained by the facility staff and provided to the resident/patient on request. Smoking will only be in designated areas. Smoking materials will be returned to the facility staff upon completion of smoking ...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy 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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			

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	Based on observation, interview and record review, the facility failed to provide treatment to prevent complications of enteral feeding for 1 of 3 residents reviewed for tube feeding, (Resident 58). Findings include: On 5/15/19 at 11:00 a.m., Resident 58 was observed lying on her back in bed. She had a tube feed on, and running continuously. She was grimacing, squirming, kicking her legs back and forth, and calling out, "I need to throw up" repeatedly. LPN 25, who was at a nurse's cart outside of Resident 58's room, was notified. On 5/15/19 at 11:10 a.m., LPN 25 placed a towel over the Resident's chest, and put a small dish on top of the towel below the Residents mouth in case she vomited. LPN 25 indicated she could not understand what the Resident was saying. On 5/15/19 at 11:34 a.m., Resident 58 was observed from the hall as she continued to be grimacing, squirming, kicking her legs back and forth, coughing and gagging, and called out, "I need to throw up," and "water, water, water." CNA 28 passed Resident 58's room twice, without checking on Resident 58. LPN 25 prepared a medication cup for another resident, and entered a room across the hall from Resident 58, and closed the door, as Resident 58 continued to call out. On 5/15/19 at 11:40 a.m., LPN 25 was asked to observe Resident 58 again. LPN 25 walked into the room, without knocking, and asked, "What do you want?" Resident 58 called out for "water." LPN 25 left the room. On 5/15/19 at 11:42 a.m., LPN 25 returned to	F 0693	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident # 58 was not harmed. Chest x-ray was negative for abnormal findings. MD notified. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: Residents who are NPO are at risk. Nurse 25 has been educated on complications of enteral feedings related to NPO orders and physician notification with change in condition. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The DON/designee will in-service all licensed nurses on: 1.Care of a patient with an enteral feeding. 2.NPO orders. 3.Physician notification with change in condition. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the DON/designee:	06/14/2019

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	Resident 58's side with water, and placed a straw in her mouth. Resident 58 took several sips of the water. On 5/15/19 at 11:58 a.m., LPN 25 was observed as she changed Resident 58's tube feeding. She stopped the hanging tube feed, disconnected it, and hung the next bottle. She provided Resident 58 with several more sips of water through a straw. Only at the time LPN 25 hung a new tube feed bottle, was the resident tube feed turned off. On 5/14/19 at 1:50 p.m. a comprehensive medical record review was completed for Resident 58. A most recent comprehensive assessment was a minimum data set (MDS) assessment dated 4/24/19. The MDS indicated Resident 58 was severely cognitively impaired, required maximum assistance for all activities of daily living (ADLs), and required the use of tube feedings to meet all nutritional needs. Resident 58 had physician orders which included but were not limited to: a NPO [nothing by mouth] diet, Enteral Feed order: "...every shift observe for signs and symptoms of dehydration, nausea, vomiting..." Resident 58's Medication Administration Record was reviewed for 5/15/19: Pain monitoring using verbal/non-verbal 0-10 scale, every shift for monitoring level of comfort-coded 0 [no pain] Every shift observe for symptoms of dehydration, nausea, vomiting... coded as completed with a check mark. No indication of noted nausea. No nursing progress note, assessment, or event/incident, or vital signs were recorded to		1. Daily observation of residents with an enteral feeding to validate positioning and compliance with diet orders. This audit will be completed 5 times a week for 30 days, then three times a week for 30 days, then weekly for 30 days. 2.The DON/Designee will monitor the residents' progress notes 5 times a week for physician notification of change in condition, this will be an ongoing process of this facility. 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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	document notification of the physician for Resident 58's acute nausea. A nursing progress note, dated 5/16/19 at 7:22 p.m., indicated, "... MD [Medical Director] and family made aware that resident is NPO and was given water by error, received order from MD stat chest x-ray 2 views to R/O [rule out] aspiration...." Resident 58 had care plans which included but were not limited to, a care plan for her diet that indicated, "... [Resident 58] is NPO and requires GT [tube feeding] r/t[related to] refusal to eat, inadequate po [by mouth] intake and inability to meet needs via po intake alone due to disease process of vascular dementia... monitor/document report to MD as needed for: ...nausea/vomiting...." During an interview with the Director of Nursing (DON), on 5/17/19 at 9:08 a.m., she indicated nursing staff should assess residents with acute changes in condition and notify the MD of those changes and document them in the Resident's medical record. On 5/17/19 at 10:00 a.m., the DON provided a copy of current facility policy titled, "Notification of Significant Condition Changes, Medical Treatment or Incidents" dated, 10/30/13. The policy indicated, "... the family or guardian, if applicable, will be notified in a timely manner of significant changes such as incidents/accidents.... notification of family or guardian of significant changes will be made by phone by the department affected and documentation of this process written in the progress notes...." 3.1-44(a)(2)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			
	Based on observation, interview and record review, the facility failed to maintain standards of professional practice by not disposing of, in a timely manner, a tracheostomy collection container, for 1 of 3 residents reviewed for respiratory care (Resident 61). Findings include: During an initial interview with Resident 61 on 5/13/19 at 9:58 a.m., he indicated, he was the only resident on the 200 hall who had a Tracheostomy, and facility staff never came to help with it. He pointed to his bedroom dresser where a collection container was observed to be uncovered, and 1/3 full of a cloudy brown substance. The container was dated 4/29/19. On 5/14/19 at 1:41 p.m., Resident 61's collection container was observed for a second day, uncovered, dated 4/29, and 1/3 full of a cloudy brown substance. On 5/15/19 at 9:02 a.m., Resident 61's collection container was observed for a third day, uncovered, dated 4/29, and 1/3 full of a cloudy	F 0695	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Suction container changed for resident 61. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: Residents requiring suctioning are at risk for this alleged deficient practice. Staff to be in serviced on Mechanical Ventilator Equipment Change Out policy. An audit will be completed of all residents with respiratory equipment to validate respiratory equipment is replaced as scheduled. **Measures put in place and systemic changes made to ensure the alleged deficient**	06/14/2019

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	brown substance. During an interview with Respiratory Therapist (RT) 15, on 5/15/19 at 11:27 a.m., she indicated Resident 61's Tracheostomy collection container was supposed to empty weekly at minimum, and was a shared duty between RT staff and nursing staff. She observed the collection container and indicated it was 1/3 full of sputum material, (a mixture of saliva and mucus from the respiratory tract) and should have been emptied. On 5/15/19 at 10:14 a.m., a comprehensive record review for Resident 61 was completed. A most recent comprehensive assessment was a quarterly minimum data set (MDS) assessment dated 4/24/19. The MDS indicated Resident 61 was cognitively intact, required tracheostomy care, and had active diagnosis' which included but were not limited to: HIV, cough, and tongue cancer. Resident 61 had physician orders which included but were not limited to instructions for his, "...suction equipment for use with his tracheostomy to be changed weekly and as needed every day shift every Saturday for Infection Control...." On 5/16/19 at 11:45 a.m., Regional Clinical Consultant 8 provided a copy of current facility policy titled, "Mechanical Ventilator Equipment Change-Out" dated, 11/1/16. The policy indicated, "...all equipment no in continuous use will be stored in a set-up bag to avoid contamination and accidental disposal...Suction Canister- changed one time per week and PRN [as needed], canister will be disposed of according to Infection Control guidelines...." 3.1-47(a)(4) 3.1-47(a)(5)		**practice does not recur:** The DON/Designee will in-service nursing staff and respiratory staff on: 1.Mechanical Ventilator Equipment/Respiratory Equipment Change Out policy. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the DON/Designee 1.5 residents requiring suctioning to have equipment checked for weekly change out weekly for 1 month, then every other week for 1 month and then monthly for 4 months. 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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	3.1-47(a)(6)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidenced by: Based on interview, and record review, the facility failed to follow a timely two step method, to ensure staff were screened for tuberculosis, for 1 of 10 employees reviewed for TB. Findings include: On 05/16/19 at 1:30 p.m., a random sample of 10 employee records were reviewed. Certified Nurse Aid 10's employee record indicated she was hired on 02/28/19. The 1st step test was placed on 0 2/26/19, and read as negative on 02/28/19, The 2nd step was placed on 04/30/19, and read as negative on 05/02/19.	F 9999	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** 2 Step TB test administered for C.N.A. 10. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: No residents were affected by this alleged deficient practice. All employee files to be audited for compliance, TB tests will be administered as needed. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Executive Director or designee will in-service HRM, SDC, and DON: 1.2 step TB testing **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the Executive	06/14/2019

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	05/17/2019

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

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	On 05/17/19 at 11:00 a.m., during an interview, the Administrator indicated the facility followed the State requirements for tuberculosis testing.		Director/Designee 1.Newly hired staff TB tests to be reviewed weekly x 4 weeks and monthly x 4 months. 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	