STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155664	A. BUILDING 00 B. WING	10/29/2019

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 the Investigation of Complaints IN00305963, IN00306987, IN00307375, and IN00307389. Complaint IN00305963 - Unsubstantiated due to lack of evidence. Complaint IN00306987 - Substantiated. Federal deficiencies related to the allegations are cited at F689. Complaint IN00307375 - Substantiated. No deficiencies related to the allegation are cited. Complaint IN00307389 - Unsubstantiated due to lack of evidence. Survey dates: October 28, and 29, 2019 Facility number: 010666 Provider number: 155664 AIM number: 200229930 Census Bed Type: SNF/NF: 91 Total: 91 Census Payor Type: Medicare: 10 Medicaid: 56 Other: 25 Total: 91 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on Novemer 7, 2019.	F 0000	***The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Eagle Creek Healthcare Center.***	
F 0689 SS=G	483.25(d)(1)(2) Free of Accident			

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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Bldg. 00	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 staff utilized proper transfer technique with a Hoyer lift and failed to document a post fall assessment of a resident who fell during a transfer resulting in fracture of the right tibia for 1 of 3 residents reviewed for falls (Resident H). Findings include: A report titled, "Indiana State Department of Health Survey Report System," indicated, on 10/18/19 at 12:30 p.m., Resident H had an assisted fall in her room. Resident H initially did not voice any complaints of pain, but the following day was voicing complaints of pain to her hips. X-rays were obtained of both hips that showed no fracture. On 10/21/19 at approximately 11:30 a.m. the resident was complaining of right hip pain, and was sent to the emergency room (ER) where x-rays showed a fracture of the right distal tibia...The interdisciplinary team (IDT) reviewed and transfers will be via Hoyer lift [an assistive device that allows a person to be transferred between a bed and a chair or other similar resting places, by the use of electrical or hydraulic power] at this time...." During an observation, on 10/29/19 at 3:34 p.m., Resident H was lying in bed with eyes closed, and	F 0689	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident H no longer resides in the facility. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents requiring mechanical transfer have the potential to be affected. An audit of all residents that require a mechanical lift for transfers has been completed, and their plan of care with appropriate interventions has been reviewed and updated as needed. Transfer requirements has been added to the resident kardex. **3.What measures will be put into place and what systemic**	11/26/2019

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	the television on. An electronic Hoyer lift was observed outside her door in the hallway. A record review was completed for Resident H on 10/29/19 at 1:50 p.m. Diagnoses included, but were not limited to, delusional disorder, dementia without behavioral disturbance, and cerebral infarction. An assessment for Resident H titled, "Fall Observation Tool," dated 8/5/19, indicated the resident had poor recall and judgement. She was non-ambulatory, and required a total mechanical lift for all transfers. Resident H had no history of falls. A quarterly Minimum Data Set (MDS) assessment, dated 10/3/19, indicated Resident H had the ability to make herself understood and to understand others. The resident was unable to complete the interview, and she had short and long term memory problems. The resident was total dependence of two or more people physical assist for bed mobility, transfers, locomotion on the unit, toileting, and personal hygiene. She did not walk in the room or corridor. There was no history of falls since admission or the prior assessment. A risk for falls care plan for Resident H was not updated after the 8/5/19 Fall Observation Tool and did not indicate the use of a Hoyer lift for transfers. The fall care plan was not updated after the quarterly MDS on 10/3/19 and did not indicate the resident was a total dependence of two or more people physical assist for bed mobility, transfers, locomotion on the unit, toileting, and personal hygiene. The intervention to use a Hoyer lift for transfers was added to the care plan on 10/19/19.		**changes will be made to ensure that the deficient practice does not recur;** All nursing staff will be educated on fall protocol and appropriate use of mechanical lift by DON/designee. Nursing staff will complete competencies on resident transfers with emphasis on use of mechanical lift. Licensed nurses have been educated on plan of care implementation and revisions with emphasis on care needs updated on the resident kardex. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The DON/designee will audit the care plans and kardex to validate they are reflective of transfer status of 5 residents per day for 4 weeks, 5 residents weekly for 4 weeks and 5 residents per month for 4 months. The DON/designee will watch 5 transfers weekly x 4 weeks, then 10 transfers monthly for 2 months, and then 5 transfers monthly for 3 months. The DON/designee will interview 5 staff members weekly x 4 weeks, then 10 staff members monthly x 2 months, then 5 staff members monthly x 3 months to ensure the	

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	An assessment for Resident H, titled, "Fall Risk Observation", dated 10/19/19, indicated mechanical lift for all transfers. The assessment indicated Resident H had no history of falls. An assessment for Resident H, titled, "Post Fall Assessment", dated 10/19/19, indicated the resident had pain in the right lower leg. Resident H indicated, CNA 14 sat her on the edge of the bed and put her arms under the residents arms in attempt to transfer resident from bed to chair, when she lifted the resident she fell down to the ground on the right side of her body. No assistive device was being used. Current actions in place included bed in lowest position, call light within place, teaching moment with CNA's that resident was a 2 person transfer. A Progress Note for Resident H, dated 10/19/2019 at 3:09 p.m. by License Practical Nurse (LPN) 8, indicated the resident had complaints of pain to both hips and bilateral lower extremities, post fall the previous day shift. A digital physician technology system was used and an order was received for stat (immediate) x-rays to both hips. Tylenol (analgesic) was given for pain. A Progress Note for Resident H, the Director of Nursing (DON) created as a late entry on 10/20/19 at 2:25 p.m., indicated on 10/19/19 at 3:50 p.m. results of bilateral hip x-rays indicated, no acute findings or dislocation, degenerative changes affecting the hips bilaterally. A Progress Note for Resident H indicated, on 10/21/2019 11:38 a.m., the DON spoke with the son-in-law who indicated, the resident was still complaining of right hip pain, and he requested she be sent to the ER for further evaluation.		proper use of resident kardex. The Director of Nursing or Designee will report to the QAPI committee findings and the QA committee will determine when compliance is achieved or if ongoing monitoring is required.	

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	An emergency room (ER) report for Resident H, dated 10/21/19, indicated the resident was brought in by the son-in-law for continued right hip pain after a fall that occurred 10/18/19. Resident H had an x-ray of her right hip 2 days ago that was negative. Her son-in-law was concerned because she continued to have severe pain. The mechanism of the fall was not 100% clear. The patient stated that she was dropped and that her leg folded under her. The son-in-law was told that they had to lower her to the floor, but was later told that the patient may have slipped out of her chair. An X-ray report for Resident H that was performed at the hospital on 10/21/19, indicated there was a minimally displaced obliquely oriented spiral fracture of the distal tibia without extension to the tibiotalar (ankle) joint space. An Employee Corrective Action Form, dated 10/21/19, indicated RN 13 received a Final Written Warning for performance/policy violation and safety/carelessness. The form indicated RN 13 failed to document a fall or perform any post fall assessment. An Employee Corrective Action Form, dated 10/21/19, indicated CNA 14 received a Final Written Warning for performance/policy violation and safety/carelessness. The form indicated CNA 14 failed to appropriately transfer a dependent resident. A fall interdisciplinary (IDT) note for Resident H, dated 10/22/19 at 9:00 a.m., by the DON, indicated the resident had an assisted fall during a transfer from the bed to a chair where the resident's knees buckled and had to be lowered to the floor on			

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	10/18/19. Resident was immediately transferred back into bed and had remained there for the rest of the day and night. Resident initially had no complaints of pain or discomfort on the day of the fall but the next day had complaints of pain to bilateral hips. The cause for the fall was known related to it was an assisted fall and IDT had implemented that resident was a Hoyer lift for all transfers. Resident returned from ER visit with fracture to right distal tibia and at that time new interventions for soft bracing with ace wrap to stabilize right lower extremity (RLE) was implemented and new pain medication had been ordered for better pain management. Will follow up with orthopedics (ortho) as ordered and clarify weight bearing status and further plan of care for fracture. A Progress Note for Resident H, the DON created as a late entry on 10/22/19 at 2:14 p.m., indicated, on 10/21/2019 11:01 p.m., Resident H returned from the hospital with her right leg wrapped with an ace wrap from knee to toes. The resident had new medication orders for Norco (narcotic analgesic) 5/325 milligrams (mg) every 6 hours as needed for pain management. Resident H would remain a Hoyer lift for all transfers. The son-in-law was to schedule a follow up appointment with orthopedics (ortho). A Progress Note for Resident H, Registered Nurse (RN) 13 created as a late entry on 10/22/19 at 4:14 p.m., indicated on 10/18/2019 at 12:45 p.m. Certified Nursing Assistant (CNA) 14 notified her Resident H had been assisted to the floor by the CNA when trying to transfer the resident from the bed to the chair per resident's request. CNA 14 indicated, she had lowered the resident to the floor to prevent her from falling when the resident's knees became weak. RN 13 found the			

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	Resident H sitting on the floor next to bed, and at that time the resident was not complaining of pain. RN 13, CNA 14, and another aide assisted the resident back into bed. An employee witness statement from RN 13, undated, indicated, "CNA came and notified writer to see the resident who was said to have been assisted to the floor by the CNA trying to transfer from bed to chair per residents request. CNA stated she lowered resident to the floor to prevent her from falling when resident's knees became weak and CNA had no choice to assist to the floor. When I arrived in room I found resident sitting on the floor next to bed. At this time resident was not complaining of any pain to any extremity and myself and two other CNA's assisted resident back into bed. Resident had no complaints and no visible injuries seen." An employee witness statement from CNA 14, undated, indicated, "Came in [Resident H] room the second time and both times she was moving around in her bed. The second time I went in she was feet out of bed head hanging on side. So I went to get her up. She said she wanted out of bed. I asked her can you pivot, she said yes. I put the chair closest to bed, she put her hand on chair proceeded to pivot and knees buckled. I laid her down, she went down on her side [got comfortable] and I went to get some help." During an interview on 10/29/19 at 3:22 p.m., LPN 7 indicated, Resident H was dependent for all care, including transfers, as she was not stable to transfer alone. LPN 7 was not present when the fall occurred, but had been told the fall occurred during a transfer process or changing position. Resident H should have been a Hoyer lift, the nurse was not sure if it was being used at the time			

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of the fall.

A confidential interview during the survey indicated, when CNA 14 was transferring Resident H from the bed to the chair, the resident's legs buckled and she was lowered to the floor. Not sure how the fracture occurred. CNA 14 had been going by the documentation in PCC (electronic documenting system) that indicated the resident was a one person assist for transfers. Staff had always used the Hoyer as the resident was unable to stand or bear weight, and the family preferred the Hoyer to be used.

A confidential interview during the survey indicated, CNA 14 was newer to the facility and did not know Resident H well. When she attempted to transfer the resident by scooting her from the bed to her chair, the resident was lowered to the floor. Other staff always used the Hoyer for transfers.

During an interview, on 10/29/19 at 4:49 p.m., the DON indicated on 10/18/19 Resident H had been sitting on the side of the bed, and asked to sit in a chair. CNA 14 went to transfer her from the bed to stationary chair at bedside, the resident's legs buckled, she became weak, and she lowered her to the floor. Resident H was dependent on staff for all transfers, although she did not get up often. CNA 14 indicated, the resident told her she could stand to transfer, and wanted to stand, and the aide took the resident's word for it and stood her up. PCC was up to date at the time of the fall and had indicated, the resident was a 2 person dependent transfer. Since the incident PCC was updated and use of a Hoyer lift had been added for use during transfers. RN 13 had been given a written counseling due to she indicated she had assessed the resident following the fall, but she

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	did not document the resident as having been assessed. CNA 14 was given a written counseling due to she had not appropriately transferred the resident with 2 staff members per the resident plan of care resulting in a fall with fracture. During an interview, on 10/29/19 on 5:08 p.m., the Regional Director of Clinical Operations indicated the facility had no policy regarding fall follow up or assessments. Staff were trained during orientation what to do when a fall occurred, such as assessing the resident, post fall assessment documentation, and calling the DON, but there was nothing in writing. During an interview, on 10/29/19 at 5:23 p.m., the Administrator indicated staff to include nurses and CNA's were instructed on transfers and fall follow up during orientation. CNA 14 had documentation to indicate she had been trained. The DON indicated a document, titled, "Fall Check List", undated, was the current list being used during staff training regarding falls. The list included, but was not limited to, immediately assess the resident, take vital signs and initiate neuro checks, notify the DON/MD/NP/responsible parties, write a progress note to describe exactly what happened, initiate interventions to prevent further falls, new MD orders, and CNA's to immediately get a nurse to assess the resident and no not ever move the resident. Electronic Medical Record assessment to be completed included, Fall Follow Up, Post Fall Assessment, Fall Risk Observation, Pain Observation, Skin Grid, and Neuro Checks. This Federal tag relates to Complaint IN00306987.			

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	3.1-45(a)			