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	07/15/2019

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 IN00296700, IN00297096, IN00297532, IN00298628, and IN00300299. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00296700 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00297096 - Substantiated. Federal deficiencies related to the allegations are cited at F608, F678, and F689. Complaint IN00297532 - Substantiated. State deficiencies related to the allegation are cited at F9999. Complaint IN00298628 - Unsubstatiated due to lack of evidence. Complaint IN00300299 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: July 8, 9, 10. 11, 12, and 15, 2019 Facility number: 010666 Provider number: 155664 AIM number: 200229930 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 8 Medicaid: 63 Other: 11	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.***	

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

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	Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 23, 2019.			
F 0608 SS=G Bldg. 00	483.12(b)(5)(i)-(iii) Reporting of Reasonable Suspicion of a Crime §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section			

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	1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. Based on interview and record review, the facility failed to report a reasonable suspicion of a crime after finding a resident deceased with his Total Parenteral Nutrition (a method of feeding that bypasses the gastrointestinal tract through a vein to provide most of the nutrients the body needs) disconnected from his Peripherally Inserted Central Catheter (a thin, soft, long catheter or tube with the tip of the catheter positioned in a large vein that carries blood into the heart) and a syringe in his hand (Resident C) for 1 of 3 deaths reviewed. Findings include: During an interview on 7/10/19 at 9:57 a.m., the Deputy Coroner indicated she had concerns with the death of Resident C on 6/1/19, and found it suspicious related to multiple reasons. The resident was found with a syringe in his hand, and there was a crushed up white substance found on the bedside table. The coroner had instructed the nurse on the phone to close Resident C's door and not touch anything until she got to the facility. The coroner called the police herself, and the coroner and police entered the facility together. When she arrived there were 3 individuals going through the resident's room, they were attempting to clean the room to include mopping and the trash cans had been emptied. When asked where the resident's personal belongings were, such as cell phone and wallet, a staff member brought her a credit card only. The coroner's office performed a full autopsy due to concerns, and were awaiting toxicology results.	F 0608	F608 **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C expired. **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 other residents residing in the facility have the potential to be affected. A review of resident's charts that have passed away in the facility in the last 30 days has been conducted to identify any cause that would make the death suspicious. Any findings will be reported per the ISDH reporting guidelines. **1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Executive Director and DON will be in serviced by Regional Director of Clinical Operations/designee on	08/07/2019

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	She indicated she found the whole circumstance surrounding his death suspicious. Staff statements before and after management got involved, totally changed, "it was wild," and "it was lie after lie told" to her. A written statement by the officer in the Homicide Branch, Criminal Investigation Unit of [city police department] indicated an officer responded to a death investigation on 6/1/19. The healthcare facility contacted the Coroner's office first, and indicated the decedent had a syringe in his hand when he was found. The Coroner's office advised the facility not to touch anything and leave the scene as they found it. When the Coroner and the Homicide Investigator responded to the scene the syringe was now in a plastic bag, the body was covered with a sheet, and his clothing was bagged up. The Coroner and Homicide Investigator attempted to gather information about what had happened to the decedent, and who moved the items in the room. Both the Coroner and Homicide Investigator kept getting "the run around" with a lot of "I don't know answers." A supervisor had to be called in attempt of answering some simple questions for the investigation that the onsite caregivers should have or have access to. A written statement from the lead detective in the Homicide Branch, Criminal Investigation Unit of [city police department], in charge of the death investigation of Resident C indicated on 6/1/19 at approximately 10:45 a.m., he was contacted by the Deputy Coroner of a death investigation at the facility. In the limited information shared to the coroner by a staff person at the location, the decedent/patient was said to have an empty syringe in his hand. The coroner instructed the staff to leave the scene as it was found. The lead		ISDH Incident Reporting Policy. All potential reportable events will be reviewed by Regional Director of Clinical Operations to ensure proper reporting. All staff has been in serviced on the reporting guidelines. **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 ED/Designee will audit reportable events daily. This will be an ongoing practice of the facility. The Executive Director or Designee will report to the QAPI committee findings monthly.	

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	detective requested a uniformed officer to meet him and the coroner at the scene. Upon arrival, the lead detective learned from the coroner that items at the scene had been moved and the scene disturbed. Resident C was observed on his back lying in a hospital bed with a sheet pulled up to his neck. The coroner advised the lead detective that the empty plastic syringe had already been removed from his hand and placed in a plastic envelope. RN 13 was asked if she knew about the empty syringe found in the decedent's hand, and she responded she didn't know what was inside the syringe or how the resident managed to acquire it. They also inquired about a small pill dosage cup with what appeared to be a small "mushy" pill that possibly was spat out into the cup, and RN 13 indicated she didn't know what type of medication the pill to be or how it came to be in the room. There was a bundle of personal clothing already wrapped in a plastic bag sitting atop a dresser, and RN 13 indicated she didn't know how the clothing came to be in that manner. There was another full plastic syringe in a drawer, numerous pill dosage cups on a dresser and some on the floor beneath the bed, a plastic baggy with a yellow fluid beneath the bed, and a blue capsule found on the closet floor. After receiving conflicting information and inadequate answers to questions, the lead detective asked to speak to a supervisor, and was subsequently contacted via phone by the interim Director of Nursing (DON). Review of reports, titled, "Indiana State Department of Health", dated 5/1/19 - 7/8/19, on 7/9/19 at 2:28 p.m. The reports indicated, there was no state reportable incident submitted regarding the death of Resident C. Record review was completed for Resident C on 7/9/19 at 10:25 a.m. The record indicated, the			

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	resident was re-admitted to the facility from the hospital on 4/26/19, with diagnoses to include, but were not limited to: postsurgical malabsorption, anxiety disorder due to known physiological condition, depressive episodes, post-traumatic stress disorder, adjustment disorder, bipolar disorder, and chronic pain disorder. Review of Admission Minimum Data Set (MDS), dated 3/5/19, indicated, Resident C had the ability to make himself understood and to understand others and no cognitive deficit. Resident C had no signs and symptoms of delirium, no behaviors, or rejection of care. During an interview on 7/9/19 at 4:00 p.m., the Regional Director of Clinical Operations indicated, the CNA (not sure who it was) got CNA 15 because she could get him to respond when she called for him to deliver a tray. Resident C was on the bed. CNA 15 went and got RN 13 and the other CNA grabbed the RT. The RT and nurse assessed the resident together, RT asked code status and nurse said full code. RT started CPR, nurse came back and said resident was DNR and CPR stopped. The resident was found with a 10 ml (normal saline) NS syringe in his hand that was a flush syringe from the facility. The Regional Director of Clinical Operations indicated he was not a drug user and she did not believe he would have done that. On 7/9/19 at 4:09 p.m., the Regional Director of Clinical Operations indicated, the resident was not a known drug user, and the situation did not appear to be suspicious in nature. The DON indicated the resident had co-morbidities that could have contributed to his death. The ED indicated she agreed with the DON that the resident had multiple co-morbidities, and he			

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	unfortunately passed away from those. The resident was very sick, and she did not feel this was an incident that should have been state reported. On 7/10/19 at 9:18 a.m., the Regional Director of Clinical Operations indicated the nurse said she bagged the syringe before the coroner arrived, but the police bagged the resident clothing. During an interview on 7/10/19 at 1:19 p.m., RN 13 indicated Resident C was found with his Total Parenteral Nutrition (TPN) (a method of feeding that bypasses the gastrointestinal tract through a vein to provide most of the nutrients the body needs) disconnected but running, a syringe on his hand, and she took the syringe and put it in a bag, and gave it to 911. When 911 came they said he was gone and there was nothing they could do. When the nurse called the on-call MD, he asked if resident was expected to die, and when the nurse responded no. She was instructed to call the coroner's office. The coroner asked about what transpired, and instructed the nurse to leave the room as was until she arrived. Police entered with the coroner. The coroner asked why the residents clothing were bagged, nurse indicated she was not sure but guessed because the resident liked to bag his clothing. She could not name staff that were observed by the coroner as cleaning up the room upon her arrival to the facility. The resident had a type of syringe in his hand the nurses in the facility used to flush the resident's Peripherally Inserted Central Catheter (PICC) (a thin, soft, long catheter or tube with the tip of the catheter positioned in a large vein that carries blood into the heart), but not sure where he got the syringe as she had not given it to him, and he did not have a MD order to flush his PICC. Nurse 13 indicated she had no idea what happened to the			

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	resident's personal belongings to include his cell phone or wallet. During an interview on 7/11/19 9:29 a.m., the MD indicated Resident C's death was unexpected. The MD had recently seen the resident and treated him in the hospital, and to his knowledge the resident had always been a full code, as reflected in his documentation of the resident. The MD had no knowledge of a new POST form being filled out to change the resident's code status. During an interview on 7/11/19 at 5:11 p.m., the Nurse Practitioner (NP) 18 indicated she was surprised when she was informed the resident had passed away, as during their last conversations, the resident told her he wanted to go home. There could always be an option that the resident could have hurt himself as he struggled with tragedies causing him to be psychologically impaired from his past. Review of a policy provided by the Indiana State Department of Health, Division of Long Term Care, titled, "Incident Reporting Policy", dated 7/15/15. The policy indicated, "Occurrences that directly threatens the welfare, safety, or health of a resident ...Examples ...death of a resident that is unusual, violent, suspicious, or resulted from an accident ..." This Federal tag relates to Complaint IN00297096.			
F 0678 SS=J Bldg. 00	483.24(a)(3) Cardio-Pulmonary Resuscitation (CPR) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and			

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	subject to related physician orders and the resident's advance directives. Based on interview and record review, the facility failed to ensure residents' choices of code status were documented consistently in the medical record and the physician was aware of the residents' choices (Residents C, B, and N) for 3 of 4 residents reviewed for code status, and failed to follow the Cardiopulmonary Resuscitation (CPR) procedure for an unresponsive resident for 1 of 3 residents reviewed for death (Resident C). The Immediate Jeopardy began on May 7, 2019 when a Physician Orders for Scope of Treatment (POST) form was signed and placed in the resident's medical record indicating Resident C was a Do Not Resuscitate (DNR). Physician and Nurse Practitioner notes indicated the resident was a full code, and there was no documentation the resident had requested to change his code status. Resident C was found unresponsive on 6/1/19. CPR was started due to staff's belief Resident C was a full code and then stopped when the DNR code was found in his medical record. The Administrator and Regional Director of Clinical Operations Nurse Consultant were notified of the Immediate Jeopardy at 5:38 p.m. on 7/11/19. The immediate jeopardy was removed on 7/12/19, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. Record review was completed for Resident C on 7/9/19 at 10:25 a.m. The record indicated, the resident was re-admitted to the facility from the hospital on 4/26/19, with diagnoses to include, but	F 0678	F678 **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C expired. Resident B and Resident N no longer reside in the facility. - 5/7/19 Social service spoke with resident C in regards to code status. Resident C requested to change code status to a Do Not Resuscitate (DNR). A POST was established and signed by resident C. The POST did not have a wet signature by the physician. An order was entered into the electronic medical record for a DNR. The order was not signed by the physician. Resident C's medical record did not reflect documentation of resident C's choice to change his code status or that the physician was notified of resident C's wish to change code status. -6/1/19 Resident C was found without a pulse or respirations. Cardiopulmonary resuscitation (CPR) was initiated and upon verification of POST form it was discontinued. Resident C expired. **2. How other residents having the potential to be affected by the same deficient practice will**	08/07/2019

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	were not limited to: postsurgical malabsorption, anxiety disorder due to known physiological condition, depressive episodes, post-traumatic stress disorder, adjustment disorder, bipolar disorder, and chronic pain disorder. An admission Minimum Data Set (MDS) assessment, dated 3/5/19, indicated Resident C had the ability to make himself understood and to understand others. He had no cognitive deficit, no signs and symptoms of delirium, no problems with his memory, no behaviors, or rejection of care. He required supervision with 1 person physical assistance for bed mobility, transfers, walking in the room and corridor, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. Review of a document created by the Medical Director (MD), for Resident C, titled, "Advanced Care Planning," dated 4/29/19. The documented indicated, "A Voluntary Advanced Care Plan encounter was completed today...he is a full code." A History and Physical (H&P) signed by the Medical Director (MD), dated 4/29/19, indicated Resident C was "Code Status: Attempt Resuscitation [CPR]. Full Scope of Treatment." A Progress Note signed by Nurse Practitioner (NP) 21, dated 5/1/19, indicated Resident C was "Code Status: Attempt Resuscitation [CPR]. Full Scope of Treatment." A Progress Note signed by the MD, dated 5/6/19, indicated Resident C was "Code Status: Attempt Resuscitation [CPR]. Full Scope of Treatment." A Progress Note signed by NP 18, dated 5/7/19,		**be identified and what corrective action(s) will be taken;** All other residents residing in the facility have the potential to be affected. An audit has been conducted to validate all residents residing in the facility code status is accurate and in accordance with the residents choice and/or advanced directives, a signed physician order for the code status, and a progress note has been entered in the medical record with residents wishes. All residents' plan of care has been reviewed and revised if necessary. All current POST forms have been removed from the resident's medical record and a revised POST will be completed with the resident, resident's representative, and physician before replacing in the medical record. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All licensed staff have been educated on the General Code Status policy with emphasis on obtaining a verbal or written physician order for all code statuses on admission and with any resident request to change a current code status, order entry	

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	indicated Resident C was "Code Status: Attempt Resuscitation [CPR]. Full Scope of Treatment." Physician order, dated 5/7/19, indicated Do Not Resuscitate (DNR) with no directions specified for order. Review of a Physician Orders for Scope of Treatment (POST) form for Resident C, dated 5/7/19 indicated DNR. The form had the resident's and physician's copied/pre-stamped signature. Review of forms for Resident C, titled, "Telephone Orders", dated 5/7/19, indicate there were no orders received or written for a DNR code status. An assessment in the electronic medical record (EMR) for Resident C, titled, "48 Hour Baseline Care Plan," dated 5/7/19, indicated code status was DNR. A Progress Note signed by NP 18, dated 5/10/19, indicated Resident C was "Code Status: Attempt Resuscitation [CPR]. Full Scope of Treatment." A Progress Note signed by NP 18, dated 5/14/19, indicated Resident C was "Code Status: Attempt Resuscitation [CPR]. Full Scope of Treatment." A Progress Note signed by NP 18, dated 5/15/19, indicated Resident C was "Code Status: Attempt Resuscitation [CPR]. Full Scope of Treatment." A Progress Note signed by NP 22, dated 5/22/19, indicated Resident C was "Code Status: Attempt Resuscitation [CPR]. Full Scope of Treatment." On a Progress Note, dated 6/1/2019 at 8:00 a.m., Respiratory Therapist (RT) 12 indicated, "Called to resident's room by Certified Nursing Assistant		into the medical record, plan of care updated to reflect residents' choices, documentation of wishes in resident progress notes and verification of the residents' code status prior to initiating CPR. All licensed staff have been educated on POST form with emphasis on physicians' notification of resident wishes and obtaining a wet signature. **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 review all new admissions for current code status, verified physician order, documentation, and updated plan of care. This will be an on-going practice for the facility. The DON/designee will review all new orders obtained for a change in the resident's code status to ensure there is a verified physician order, documentation in the medical record, and an updated plan of care. A mock code will be conducted on each shift 1 time monthly to ensure competency for no less than 6 months. Medical records/designee will conduct an audit one time weekly to ensure there is a wet signature on the POST form if it is initiated in the building. The Director of Nursing or	

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	[CNA] to assess resident, found resident unresponsive with cold extremities. Registered Nurse [RN] attempted to arouse resident without success, I attempted sternal rub without success also. Code blue was called and 911 was called, chest compressions were started, and the crashed cart was retrieved. Informed about 2 minutes in resident was a no code and stopped procedures." On a Progress Note, dated 6/1/2019 at 9:08 a.m., Registered Nurse (RN) 13 indicated, "The CNA came to call writer at about 8:00 a.m. that resident didn't respond to her call. On getting to the room, resident was found unresponsive, no pulse or respiration noted, 10 ml [milliliter] empty syringe was on his hands. Total parenteral nutrition [TPN] was running but was not connected to resident. Syringe was put in a bag. Respiratory therapist started CPR, code blue and 911 called before writer checked his code status and it was DNR. 911 was already in the building by the time writer went back to resident room. 911 checked him and asked for a copy of his code status, same was provided. They said he has passed ...." On 7/10/19 at 9:20 a.m., the Regional Director of Clinical Operations provided a statement, with no signature to identify writer, dated 6/1/19. The statement indicated, "Writer spoke with all parties involved in regards to RHC [respirations have ceased] of [Resident C]. CNA was delivery morning tray and noted resident would not answer her, she asked another CNA to come with her to see if this was normal behavior for resident, and she didn't normally work on that side. Second CNA noted that they needed additional assistance. First CNA got RT and second CNA retrieved nurse. While in room RT assessed and noted resident to be without pulse and respirations, nurse indicated that resident was a		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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	full code. RT started measures for life saving efforts. Nurse left room to call 911 and checked resident code status and noted he was a DNR. Nurse returned to room and notified RT of code status and measures were stopped. EMT's [emergency medical technicians] were entering building and information provided to them. Nurse called on call and was told to call coroner ...." During an interview on 7/9/19 at 3:20 p.m., RT 12 indicated he and the nurse were called to Resident C's room by the aides. RT 12 asked RN 13 code status and was told full code. So upon arriving in the room looked at resident, assessed with no response, and CPR was initiated. He asked that code be called overhead and call 911 and they did. He told CNA to get crash cart and he initiated chest compressions, then when crash cart arrived he used the ambu bag. Nurse arrived and said resident was no code, so CPR stopped. He told RN 13 to call 911 and tell them not to come. But 911 had arrived, and asked questions, he explained resident was no code, showed 911 paperwork, and that was it. During an interview on 7/9/19 at 4:00 p.m., the Regional Director of Clinical Operations indicated, the CNA (not sure who it was) got CNA 15 because she could not get him to respond when she called for him to deliver a tray. Resident C was on the bed. CNA 15 went and got RN 13 and the other CNA grabbed the RT. The RT and nurse assessed the resident together, RT asked code status and nurse said full code. RT started CPR, nurse came back and said resident was DNR and CPR stopped. During an interview on 7/10/19 at 9:57 a.m., the Deputy Coroner indicated, she had concerns with the death of Resident C, and found it suspicious			

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	related to multiple reasons. The coroner's office performed a full autopsy due to concerns, and were awaiting toxicology results. She indicated she found the whole circumstance surrounding his death suspicious. Staff statements before and after management got involved, totally changed, "it was wild", and "it was lie after lie told" to her. During an interview on 7/10/19 at 1:19 p.m., RN 13 indicated she was in a different resident's room, when CNA 15 come to get her, they had been taking a tray in to Resident C and he did not respond. The nurse called out, and he did not respond. She told the RT the resident was a full code, but she would go check, and when she checked found he was a DNR. The nurse called 911 before returning to the room. Resident C was found with his Total Parenteral Nutrition (TPN) (a method of feeding that bypasses the gastrointestinal tract through a vein to provide most of the nutrients the body needs) disconnected but running, a syringe on his hand, and she took the syringe and put it in a bag, and gave it to 911. When 911 came they said he was gone and there was nothing they could do. When the nurse called the on-call MD, he asked if resident was expected to die, and when the nurse responded no, she was instructed to call the coroner's office. During an interview on 7/11/19 9:29 a.m., the MD indicated Resident C's death was unexpected. The MD had recently seen the resident and treated him in the hospital, and to his knowledge the resident had always been a full code, as reflected in his documentation of the resident. The MD had no knowledge of a new POST form being filled out to change the resident's code status.			

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	During an interview on 7/11/19 at 10:00 a.m., the Social Service Assistant indicated when a resident was admitted, SS would follow up to assure a POST form was filled out if the nurse has not gotten it done. SS reviewed the code status of all residents quarterly with the resident/family during care plan meetings and it was documented in a care plan note. She would notify nurse managers to make sure the code status was put into PCC (electronic medical record). If there was a change of code status/POST form, she would send out an e-mail to have nurse managers to update the documentation in PCC. To her knowledge nursing had never changed a resident's code status without letting SS know. There should always be a copy of the resident's POST form in a binder at the nurse's station. During an interview on 7/11/19 at 2:47 p.m., RN 7 indicated when Resident C first admitted to the facility he was a full code, but upon readmit from the hospital had made himself a no code. RN 7 indicated she was unsure if the MD had been notified of the resident's preference to change his code status, which would be a question for SS. She could not answer to the physician's signature being copied on the POST form, and she had never filled out a POST form in this facility. RN 7 had entered a no code physician's order in PCC on 5/7/19 in response to a POST form being given to her from SS. She thought SS was responsible for notifying the MD when a POST was filled out, and assumed SS had already made the physician aware of the new POST form, and the MD had agreed to the order. She did not verify the MD was aware before in-putting code status orders into PCC. During an interview on 7/11/19 at 3:22 p.m., the Social Service Director (SSD) indicated she had			

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	reviewed Resident C's code status with him on 5/7/19, filled out a new POST form, and given the form to RN 7, who then contacted the MD. SS was responsible for reviewing code status's with residents and documenting the information with the care plan meetings upon admit, and quarterly. RN 7 was responsible for documenting SS had contacted her regarding the resident wishing to change code status, and for documenting the MD was notified to verify the code status change, and an order was obtained. The code status was legal when the MD had been contacted for an order, not just when the MD had signed the POST form. It was her understanding the MD was aware the facility had copies of his signature on a POST form and were copying it. During an interview on 7/11/19 at 5:11 p.m., NP 18 indicated, she was not in on a discussion regarding a no code status for Resident C, those discussions were usually left for the MD. She was not aware of Resident C changing from a full code to a no code status. She was surprised when she was informed the resident had passed away, as during their last conversations, the resident told her he wanted to go home. She was not aware of the facility having pre-signed POST forms. 2. Record review completed for Resident B on 7/9/19 at 1:35 p.m., The record indicated, the resident was admitted on 4/25/19, and had diagnoses to include, but were not limited to: end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus, viral hepatitis C without hepatic coma, encephalopathy, chronic obstructive pulmonary disease, depressive episodes, attention and concentration deficit following other non-traumatic intracranial hemorrhage, history of transient ischemic attack			

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	(TIA), and hypertensive chronic stage 5 kidney disease. Review of Resident B's Physician's Orders lacked documentation of a code status or advanced directives in PCC. Review of Resident B's Progress Notes, dated 4/25/19 - 5/6/19, indicated there was no documentation regarding code status. Review of Resident C's Care Plans, indicated there was no care plan regarding code status. Review of a handwritten "Baseline Care Plan" for resident C, dated 4/25/19, indicated full code. Review of Review of Physician's Progress Notes and an Emergency Room report for Resident C, documented during her admission indicated, there was no code status documented. On 7/11/19 at 4:45 p.m., observation of Resident B's handwritten Baseline Care Plan, indicated full code. There was no documentation of a MD order for a code status, the 48 Hour Baseline Care Plan in PCC, dated 4/30/19, had the code status question left blank, and the Admission Observation Tool, dated 4/2/19, did not indicate code status preference of the resident or legal representative. The Regional Director of Clinical Operation, ED, and interim DON, indicated they could not answer as to why the resident did not have a physician's order for a code status, but indicated, the resident would have been considered a full code if there was not a MD order. 3. A record review was completed for Resident N on 7/12/19 at 3:15 p.m. The record indicated, the			

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	resident was admitted on 6/5/19, and had diagnoses to include, but were not limited to: unspecified protein-calorie malnutrition, major depressive disorder, dysphagia, hypertension, chronic pain, chronic obstructive pulmonary disease, and muscle weakness. Review of Physician's Orders for Resident N in PCC, dated 6/5/19, indicated CPR, Full Code. No directions specified for order. Review of Resident N's Care Plans, indicated, "1. Focus: [Resident] requests CPR, date initiated 6/19/2019, wishes to have CPR. Goal: If [Resident's] heart stops or they stop breathing, CPR will be initiated in honor with her wishes ongoing through the next review date. Interventions: In the event of cardiorespiratory arrest, CPR will be initiated." Review of Physician's Orders for Resident N in the hard chart, dated, 6/24/19, indicated, DNR, comfort measures. There was no physician's signature. Review of Resident N's Progress Notes, dated 6/5/19 - 6/26/19, indicated there was no documentation regarding code status. Review of Resident N's POST form in the hard chart, dated 6/24/19, indicated DNR comfort measures only. The POST form was signed by the legal representative on a form with the MD signature copied on the form. On 7/11/19 at 3:56 p.m., the Regional Director of Clinical Operations indicated a new resident was asked for code status when the nurse fills out the "Admission Observation Tool". When the orders were verified by calling the MD, and all orders and paperwork from hospital were reviewed. If a			

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resident wished to change their code status the MD was to be notified of the change to obtain a new order, and SS would fill out a new POST form although the POST form was not mandatory. SS was responsible for initiating and updating the resident care plan for advanced directives. The MD was aware the facility was using a pre-signed, copied POST form. Many MD's and nursing homes used copied forms with the MD signature on it, as the form was not valid until the MD had signed it, and he might not be in the facility for a period of time.

During an interview on 7/12/19 at 2:25 p.m., the Regional Director of Clinical Operations indicated staff were to continue CPR once it was initiated on a resident even if the resident was discovered to be a DNR after CPR was started.

On 7/11/19 at 5:01 p.m., the Regional Director of Clinical Operations provided a policy, titled, Indiana Physician-Order-for-Scope-of-Treatment [POST]", dated 5/1/18. The policy indicated, "It is the policy of the facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident. Safety is a primary concern for our residents, staff and visitors. It is the intent of this facility to honor the wishes and rights of the resident/representative to make the determination of what, if any, resuscitative measures will be implemented in the event the resident's respirations and/or pulse cease either by natural or unnatural causes. However, the facility is compelled to follow both state and federal guidelines for proper validation of this important and legal care decision. In the absence of a valid medical order and the required state or federal required documents, residents will be assigned the status of full-code upon admission. The code

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	status may be changed at any time with the proper documentation and medical order as the resident/representative desires. The staff will provide basic CPR for those desiring this treatment and not provide CPR for this who have a valid physician/authorized person order to withhold CPR per the resident/representative's request. A full-code status alerts the staff that in the event that respirations cease and/or the resident does not have a pulse [pulselessness], the staff will initiate CPR ...The facility also recognizes that not every resident desires CPR and other emergency treatment should their heart and/or respirations cease. Their wishes will be honored when proper state and federal documentation has been provided to the facility indicating the physician has discussed this option with the resident/representative and the physician/provider writers a medical order indicating CPR and other emergency measures will not be initiated ...General Indiana POST form ...c. Requirements for a valid code status must include at least the completion of the following sections/areas of the form: i. the resident name ii. resident date of birth iii. code status order selection iv. Signature of resident or authorized representative v. signature of the physician ..." On 7/12/19 at 3:01 p.m., the Regional Director of Clinical Operations provided a current policy titled, "General Code Status," dated 5/11/18. The policy indicated, "...Proper documentation and a physician/provider medical order is required for DNR status...Once CPR has been initiated at the facility, the nurse/staff member may not stop CPR following AHA guidelines, until directed to do so by a higher level of care practitioner...Only valid DNR orders will be entered into the EHR [electronic health record] profile using the Two Step Validation process found in the policy ...Two			

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	(2) Step Validation Process for entering a Code Status in EHR a.The first nurse will review the medical order from the physician. b. The first nurse will enter the data into the resident profile in the EHR. c. The first nurse will compare the EHR entry with a second nurse/licensed healthcare provider to confirm accuracy of entry with medical order. d. The second nurse/licensed healthcare provider will document accuracy by placing a note in the progress note. e. The first nurse will update the care plan to reflect appropriate code status. f. The first nurse will upload advance directives or other documents for Code Status into the EHR under the tab Advance Directives. g. The nurse will communicate the code status to other caregivers. h. The first nurse will place the information on the 24 hour summary report for review. VI. Changing a Code Status. a. The first nurse will review the medical order for new code status. b. The first nurse will download and print any previous Code Status Documents from the Advance Directives tab in the EHR. c. The first nurse will write the word VOID diagonally across the printed page and place this copy in hard chart; sign and date the form d. The nurse will change the entry in the EHR code status to the new code status using the two-step validation process. e. The nurse will upload new Code Status documents, if any, into the EHR. f. The nurse will update the care plan to the new code status. g. The nurse will communicate changes to the staff. h. Code Status changes will be placed on the 24 hour summary report to be reviewed at the morning meeting. VII. Documentation/Documents. a. A Physician/approved provider must provide a DNR order in the medical record. b.Advance Directives or other DNR forms are uploaded in EHR under the Advance Directive tab/Section. c. DNR status documents will be placed in a conspicuous area of the hard chart. d. Two Step			

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	validation requires a nurse progress note. e. A progress note should be placed by the ordering physician/provider explaining the circumstances surrounding the DNR decision...." The immediate jeopardy that began on 5/7/19 was removed on 7/12/19 when the facility conducted an audit to validate all residents' code status were accurate and in accordance with the residents' choices and/or advanced directives, signed physician orders for the code status, progress notes had been entered in the medical records with residents' wishes, and staff were in-serviced on the General Code Status policy, but the noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. This Federal tag relates to Complaint IN00297096. 3.1-37(a)			
F 0689 SS=G 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, record review, and interview, the facility failed to ensure supervision to prevent a resident from flushing his Peripherally Inserted Central Catheter (PICC) (a	F 0689	F689 **1.What corrective action(s) will be accomplished for those residents found to have been**	08/07/2019

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	thin, soft, long catheter or tube with the tip of the catheter positioned in a large vein that carries blood into the heart) for 1 of 4 residents reviewed for accidents which resulted in harm when Resident C was found unresponsive with his PICC disconnected and an empty syringe in his hand. The facility failed to ensure fall preventative interventions were implemented for 1 of 4 residents reviewed for accidents (Resident M) which had the potential for harm. Findings include: 1. Record review was completed for Resident C on 7/9/19 at 10:25 a.m. The record indicated, the resident was re-admitted to the facility from the hospital on 4/26/19, with diagnoses to include, but were not limited to: postsurgical malabsorption, anxiety disorder due to known physiological condition, depressive episodes, post-traumatic stress disorder, adjustment disorder, bipolar disorder, and chronic pain disorder. An admission Minimum Data Set (MDS) assessment, dated 3/5/19, indicated Resident C had the ability to make himself understood and to understand others. He had no cognitive deficit, no signs and symptoms of delirium, no problems with his memory, no behaviors, or rejection of care. He required supervision with 1 person physical assistance for bed mobility, transfers, walking in the room and corridor, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. A Physician order, dated 5/2/19, indicated monitor antidepressant side effects every shift related to other specified depressive episodes, not limited to: suicidal ideations, dystonia: torticollis (stiffness of neck), anticholinergic symptoms: dry		**affected by the deficient practice;** Resident C expired. Fall risk observation assessment and interventions in place for Resident M. **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 other residents residing in the facility have the potential to be affected. An audit was conducted to ensure that no other residents residing in the facility had any type of syringe in their room. All syringes will be kept locked in secure areas. An audit of all residing resident's medical record was completed to ensure that a fall risk observation assessment was completed and fall interventions were implemented. **3.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All licensed staff have been educated on the hazardous material storage policy with emphasis on ensuring syringes are maintained in secure areas. All licensed staff will be educated	

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	mouth, blurred vision, constipation, urinary retention, hypotension, sedation/drowsiness, increased falls/dizziness, cardiac abnormalities (tachycardia, bradycardia, irregular heartrate, anxiety/agitation, blurred vision, sweating/rashes, headache, urinary retention/hesitancy, weakness, tremors, appetite change/weight change, insomnia, confusion, tardive dyskinesia. A Physician order, dated 5/2/19, indicated Monitor behaviors (antidepressant) every shift related to other specified depressive episodes: withdrawn, restlessness, tearfulness, and poor intake. Non-pharmacological intervention: reassurance, encourage activities, redirection, and assess for pain. Review of behavior and depression monitoring for Resident C, dated May and June 2019. Documentation indicated, the resident had sporadic episodes of restlessness, tearfulness, and loss of appetite during the assessment periods. The documentation did not reflect the escalating behaviors documented in the nursing and NP progress notes. A review of Progress Notes for Resident C, dated 4/26/19- 6/3/19 indicated the following: On 5/2/2019 at 9:45 a.m., Registered Nurse (RN) 7 documented, "At nurses' station entering an order on another resident and this resident came up and stated, [When I say I'm in pain, I'm in pain. I'm not making this up. This is the worst pain ever you will never understand this pain.] Writer asked resident if someone had told him that he was not in pain. Resident stated that this writer told him that he wasn't in any pain and didn't need any pain medication. An hour or more prior to this interaction, writer attempted to give resident insulin per order, which he refused and writer documented previously. I did calmly inform him I		on completing fall risk observation assessments and implementing interventions on all new/re admissions, quarterly and upon change of condition. **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 to ensure syringes are locked in secure areas 5 times per week for 2 weeks, weekly x 4 weeks and monthly x 4 months. The DON/designee will audit all new/re admissions, and residents with change of condition to ensure fall risk observation assessments are completed with intervention implemented. This will be an ongoing facility practice. The electronic medical record personnel will conduct an audit of 5 residents weekly x 6 months to ensure a quarterly fall risk observation was completed. 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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	had never said anything about his pain to him or anyone and apologized if anyone had actually said this. Resident then began accusing this writer of speaking negatively about his older brother. Writer informed resident that writer was not aware that he even had any siblings, let alone had I ever talked about his sibling. Resident then began mumbling to himself before walking away." On 5/23/2019 at 6:27 p.m., the Social Service Director (SSD) documented, "Resident is currently exhibiting delusions and hallucinations. Resident stated that he was seen people and gangs in the room during his therapy session with the psych nurse and clinical social worker during counseling." On 5/27/2019 at 4:32 a.m., RN 25 documented, "Writer checked on patient and intravenous [IV] Infusion going well. Patient reminded to not stop or disconnect infusion but to let nurse know to be able to flush the line and prevent occlusion ... 9:00 p.m. patient noted in the hallway without his total parenteral nutrition [TPN] infusion as he had disconnected himself and was out and about on the unit. Patient left to go outside for a smoke and wants to be hooked up when he comes back. Nurse re-educated patient regarding importance of infusion to run continuous. Verbalized understanding but remained unhooked saying he was not ready to go on, MD's office aware of patient's non-compliance." On 5/27/2019 at 3:08 p.m., RN 13 documented, "Resident continuous [sic] to refuse for TPN to be hooked up. Verbalized that he don't need it on this shift. All efforts to make him agree to it was not successful." A report for Resident C from the Nurse			

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	Practitioner (NP), titled, "History and Physical", dated 5/22/19, indicated, the resident had been seen for an in-house psych visit and had returned to the facility. "Asked to see resident by nursing and Social Services for agitation, verbal aggression, saying things are happening that are not that are upsetting him, resident calling police, etc. He also has Post Traumatic Stress Disorder [PTSD] and has had ongoing difficulty emotionally dealing with health problems and death of his grandfather ...On admission to [facility] Quetiapine [used to treat bipolar disorder] 75 milligrams [mg] had been discontinued in the hospital, however I wrote order to restart on my 3/13/19 visit, but it appears it was not. Today he says he does not remember me from a previous visit ...and that I am a psych nurse practitioner, he said he does not want to be seen by psych and refuses to take psychiatric medication. His speech is pressured, he ranted and became progressively agitated, was clearly delusional, saying things were happening that were not ..." A care plan, date initiated 8/16/2018, indicated, " ... [Resident] uses antidepressant medication related to depression ...Interventions: Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness. Antidepressant side effects: dry mouth, dry eyes, constipation, urinary retention, suicidal ideations. Monitor/document/report to MD prn [as needed] ongoing signs and symptoms of depression unaltered by antidepressant meds: sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others,			

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	unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Psychiatric / Psychological consult as ordered." A care plan, dated initiated 10/23/18, indicated, " ...[Resident] has actual mood problem as evidenced by self-report of mood indicators during interview of feeling down, depressed, or hopeless. Resident has indications of paranoia and states people are talking about him that aren't ...Interventions: When displaying moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual - if behavior persists, notify MD for evaluation and refer to outside Psych services as needs present. When displaying feeling down, depressed, or hopeless - allow time for resident to voice feelings. When displaying trouble falling or staying asleep, or sleeping too much - ensure adequate rest periods with uninterrupted sleep at night and quiet environment to facilitate sleeping. When voicing feeling tired or having little energy - encourage to take naps during the day when needed ....Administer medications as ordered. Monitor/document for side effects and effectiveness. Behavioral health consults as needed [psycho-geriatric team, psychiatrist etc.]... Monitor/record/report to MD prn [as needed] risk for harm to self: suicidal plan, past attempt at suicide, risky actions [stockpiling pills, saying goodbye to family, giving away possessions or writing a note], intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Resident will express feelings to appropriate party During an interview on 7/9/19 at 3:20 p.m., RT 12 indicated he and the nurse were called to Resident			

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	C's room by the aides. RT 12 asked RN 13 code status and was told full code. So upon arriving in the room looked at resident, assessed with no response, and CPR was initiated. He asked that code be called overhead and call 911 and they did. He told CNA to get crash cart and he initiated chest compressions, then when crash cart arrived he used the ambu bag. Nurse arrived and said resident was no code, so CPR stopped. He told RN 13 to call 911 and tell them not to come. But 911 had arrived, and asked questions, he explained resident was no code, showed 911 paperwork, and that was it. During an interview on 7/9/19 at 4:00 p.m., the Regional Director of Clinical Operations indicated the resident was found with a 10 ml (normal saline) NS syringe in his hand that was a flush syringe from the facility. It was routine for the resident to disconnect his TPN line, and he had been known to flush his own line. If the resident wanted to go smoke, he would undo his line and would flush his own line. There was no MD order for the resident to flush his own ports as he was discouraged from doing that. During an interview on 7/10/19 at 9:57 a.m., the Deputy Coroner indicated, she had concerns with the death of Resident C, and found it suspicious related to multiple reasons. The resident was found with a syringe in his hand, and there was a crushed up white substance found on the bedside table. The coroner's office performed a full autopsy due to concerns, and were awaiting toxicology results. She indicated she found the whole circumstance surrounding his death suspicious. Staff statements before and after management got involved, totally changed, it was wild, and "it was lie after lie told" to her.			

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	A written statement by the officer in the Homicide Branch, Criminal Investigation Unit of [city police department] indicated an officer responded to a death investigation on 6/1/19. The healthcare facility contacted the Coroner's office first, and indicated the decedent had a syringe in his hand when he was found. The Coroner's office advised the facility not to touch anything and leave the scene as they found it. When the Coroner and the Homicide Investigator responded to the scene the syringe was now in a plastic bag, the body was covered with a sheet, and his clothing was bagged up. The Coroner and Homicide Investigator attempted to gather information about what had happened to the decedent, and who moved the items in the room. Both the Coroner and Homicide Investigator kept getting "the run around" with a lot of "I don't know answers." A supervisor had to be called in attempt of answering some simple questions for the investigation that the onsite caregivers should have or have access to. A written statement from the lead detective in the Homicide Branch, Criminal Investigation Unit of [city police department], in charge of the death investigation of Resident C indicated on 6/1/19 at approximately 10:45 a.m., he was contacted by the Deputy Coroner of a death investigation at the facility. In the limited information shared to the coroner by a staff person at the location, the decedent/patient was said to have an empty syringe in his hand. The coroner instructed the staff to leave the scene as it was found. The lead detective requested a uniformed officer to meet him and the coroner at the scene. Upon arrival, the lead detective learned from the coroner that items at the scene had been moved and the scene disturbed. Resident C was observed on his back lying in a hospital bed with a sheet pulled up to			

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	his neck. The coroner advised the lead detective that the empty plastic syringe had already been removed from his hand and placed in a plastic envelope. RN 13 was asked if she knew about the empty syringe found in the decedent's hand, and she responded she didn't know what was inside the syringe or how the resident managed to acquire it. They also inquired about a small pill dosage cup with what appeared to be a small "mushy" pill that possibly was spat out into the cup, and RN 13 indicated she didn't know what type of medication the pill to be or how it came to be in the room. There was a bundle of personal clothing already wrapped in a plastic bag sitting atop a dresser, and RN 13 indicated she didn't know how the clothing came to be in that manner. There was another full plastic syringe in a drawer, numerous pill dosage cups on a dresser and some on the floor beneath the bed, a plastic baggy with a yellow fluid beneath the bed, and a blue capsule found on the closet floor. After receiving conflicting information and inadequate answers to questions, the lead detective asked to speak to a supervisor, and was subsequently contacted via phone by the interim Director of Nursing (DON). During an interview on 7/10/19 at 1:19 p.m., RN 13 indicated she was in a different resident's room, when CNA 15 come to get her, they had been taking a tray in to Resident C and he did not respond. The nurse called out, and he did not respond. She told the RT the resident was a full code, but she would go check, and when she checked found he was a DNR. The nurse called 911 before returning to the room. Resident C was found with his Total Parenteral Nutrition (TPN) (a method of feeding that bypasses the gastrointestinal tract through a vein to provide most of the nutrients the body needs) disconnected but running, a syringe on his hand,			

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	and she took the syringe and put it in a bag, and gave it to 911. When 911 came they said he was gone and there was nothing they could do. When the nurse called the on-call MD, he asked if resident was expected to die, and when the nurse responded no, she was instructed to call the coroner's office. During an interview on 7/11/19 9:29 a.m., the Medical Director (MD) indicated Resident C's death was unexpected. The MD had recently seen the resident and treated him in the hospital, and to his knowledge the resident had always been a full code, as reflected in his documentation of the resident. The MD had no knowledge of a new POST form being filled out to change the resident's code status. During an interview on 7/11/19 at 5:11 p.m., NP 18 indicated, she was not in on a discussion regarding a no code status for Resident C, those discussions were usually left for the MD. She was not aware of Resident C changing from a full code to a no code status. She was surprised when she was informed the resident had passed away, as during their last conversations, the resident told her he wanted to go home. The resident was known to flush his own PICC line, although there was not a physician's order for him to do so. He had been educated not to flush his own PICC, she was not sure how he got the syringes. 2. On 7/11/19 at 10:30 a.m., a CNA and residents were observed yelling for help from the smoking area. . A resident entering from the smoking area indicated, Resident M had a seizure and there was blood everywhere. RN 30 and Qualified Medication Aide (QMA) 19 immediately responded. Resident M was observed to be			

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	sitting underneath the gazebo in the smoking area in his wheel chair with his head down, and unresponsive, there was no blood on or around the resident. Staff were unable to arouse the resident, he was rushed back to his room and put into bed. 911 responded in less than 10 minutes. The QMA indicated, to her knowledge the resident had not had a seizure before but she was not sure. Resident transported out to hospital per emergency medical services (EMS) at 10:48 a.m. During an interview on 7/11/19 at 10:50 a.m., the interim DON indicated Resident M had been in the facility approximately 4-6 weeks. On 7/4/19 the resident had a seizure, fall, and had a subsequent fracture. A record review was completed for Resident M on 7/11/19 at 11:10 a.m. The record indicated the resident was admitted on 6/14/19 and re-admitted from the hospital on 7/8/19 with diagnoses to include, but were not limited to: diabetes mellitus, cognitive communication deficit, major depressive disorder, and age related physical debility. There were no diagnoses for seizure disorder or an acute fracture. Resident M's Care Plans, included, but were not limited to: "1. 6/25/19 Focus: [Resident] is at risk for falls related to diabetes, pain. Goal: [Resident] will be free of falls through the review date. [Resident] will comply with safety measures. Intervention: Anticipate and meet [resident's] needs. Be sure the call light is within reach and encourage [resident] to use it for assistance as needed. [Resident] needs prompt response to all requests for assistance." A review of tab, titled, "Assessments", in Resident M's electronic medical record lacked			

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	documentation of a fall assessment prior to his fall on 7/4/19. A progress note by RN 7, dated 7/4/19 at 7:11 p.m., indicated, "it was reported to this RN by a CNA that resident had fallen outside in the gazebo, resident was still on the ground and had hit his head. Resident M stated he didn't know what happened or how he wound up on the ground. Other residents were outside and witnessed the incident, the resident was smoking a cigarette, had stood up and started shaking before he fell to the ground. Witnesses stated resident did hit his head when he fell. As he did not recall what happened, this RN assumed he lost consciousness momentarily. Per resident's report to this RN, resident does have a seizure disorder - he was unsure if he had a seizure. Resident reported his left hip and knee were hurting. This RN and CNA had resident remain in place. 911 was called and EMS assisted resident to get up on stretcher - resident was unable to fully sit up and refused to attempt to stand due to the pain in the hip, so EMS lifted him to the stretcher. Resident reported he was still shaking a bit after he came to. A discharge MDS, dated 7/4/19, indicated, Resident M's was independent with decision making. He required limited assistance for bed mobility, transfers, walking in the room and corridor, locomotion on and off the unit, dressing, eating, and toilet use. The resident had 1 fall without major injury since his admission or prior assessment. A review of Resident M's Physician's Orders after his fall on 7/4/19 indicated the following: On 7/9/19 "Cleanse surgical wound daily with NS [Normal saline] and pat dry. Apply xeroform			

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	[occlusive petroleum] gauze to site, cover with dry gauze, and wrap with kerlix [woven gauze]. Change daily and PRN [as needed] for soilage or displacement." On 7/9/19 "For leg, every shift may resume activity to be weight bearing as tolerated. Range of motion also can be tolerated moving forward." On 7/10/19 "report to Ortho Surgeon left leg redness and edema, every shift." During an interview on 7/11/18 at 2:22 p.m. Licensed Practical Nurse (LPN) 26 indicated, the Resident M did not have a diagnosis of seizure disorder in his resident record. The resident was still at the hospital in the emergency department and she would call and get a diagnosis for his visit. During an interview on 7/12/19 at 4:00 p.m., LPN 26 indicated, the resident had returned from the hospital that day, his return paperwork included a diagnosis of an infection, and instructions for an antibiotic. This Federal tag relates to Complaint IN00297096. 3.1-45(a)(1) 3.1-45(a)(2)			
F 9999 Bldg. 00	3.1-18 INFECTION CONTROL PROGRAM (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.	F 9999	F9999 Infection Control **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident D no longer resides in the facility.	08/07/2019

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	(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) The baseline tuberculin skin testing should employ the two-step method. For residents 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 within one (1) to three (3) weeks after the first test. 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 observation, interview, and record review, the facility failed to ensure new residents had a 2-step tuberculosis (TB) screening completed for 1 of 6 residents reviewed for tuberculosis screening (Resident D). Findings include: Random observation of TB screening indicated, Resident D who admissted on 5/17/19 had his 1st step TB injection on 5/29/19, and had discharged before the 2nd step was administered. During an interview on 7/11/19 at 2:32 p.m., Registered Nurse (RN) 7 indicted, Resident D's 1st step TB injection was just missed, it was an error. Residents frequently were admitted late in the evening, so she gave the 1st step of TB screening the next day, the 2nd step TB was given 1-3 weeks later. If residents were admitted on a weekend or		**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 other residents residing in the facility have the potential to be affected. An audit has been conducted to verify all residents' immunization record in regards to TB testing is up to date. Any resident identified not in compliance with the 2-step TB process will have be administered a TB test in accordance with the policy. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All licensed nursing staff have been educated on Tuberculosis Skin Testing 2-step policy. TB certification training has been scheduled for additional nurses to become TB certified. **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**	

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EAGLE CREEK HEALTHCARE CENTER	4102 SHORE DR INDIANAPOLIS, IN 46254

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	on her days off, the resident did not get the PPD until on Monday or after she returned. She was one of only a few nurses that were certified to give the PPD injection. PPD's were documented on an untitled form that she kept in her office, then later entered into the electronic medical record (EMR) when she got time. On 7/11/19 at 4:08 p.m., RN 7 provided a policy, titled, "Tuberculosis [TB] Skin Test Resident", titled, 3/1/16. The policy indicated, "This facility follows the CDC [Centers for Disease Control] recommendations using the health-care settings for risk assessment, management and prevention...Complete a Mantoux [TB] skin test-TST- using the two-step method upon admission..." This State tage relates to Complaint IN00297532.		The DON/designee will review all new admissions for 2-step TB testing. This will be an ongoing facility practice. Current residents will be reviewed for annual testing 5 times per week for 2 weeks, weekly for 4 weeks and monthly for 3 months. 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.	