PRINTED: 06/07/2018 FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDICAID SERVICES						
CTATEMENT OF DEFICIENCIES	W1) DD OMDED (CHIDDLIED (CLIA					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155664		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/24/2018	
	PROVIDER OR SUPPLIE CREEK HEALTHCA		STREET ADDRESS, CITY, STATE, ZIP COD 4102 SHORE DR INDIANAPOLIS, IN 46254				
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE	
Bldg. 00	IN00260476. This visit was in confective and the Investigation of the Investigation of Confection and the Investigation of Confective and Investigation of Confective and Investigation of Confective and Investigation are cited allegations are cited Complaint IN0025 lack of evidence. Complaint IN0025 lack of evidence. Complaint IN0025 Federal/State deficit allegations are cited allegations are cited allegations are cited the Investigation and Investigation	922 - Unsubstantiated due to 9879- Unsubstantiated due to 9893- Substantiated. iencies related to the d at F880, and F684. 116, 17, 18, 19, 20, 23, and 24, 10666 155664 229930	F 0000		Preparation or execution of thi plan of correction does not constitute admission or agreer of provider of the truth of the fa alleged or conclusions set fort the Statement of Deficiencies. The Plan of Correction is prep and executed solely because required by the position of Fed and State Law. The Plan of Correction is submitted in orderespond to the allegation of noncompliance cited during the Recertification and State Licensure Survey in conjunction with the following Complaint Surveys: IN00259522, IN00259879, IN00259893 and IN00260476 on April 24, 2018 Please accept this plan of correction as the provider's credible allegation of compliant	ment acts h on ared it is deral er to e	

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

TITLE

(X6) DATE

Any defiency statement 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NTDN11 Facility ID: 010666 If continuation sheet Page 1 of 6

06/07/2018 PRINTED: FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155664	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/24/2018	
NAME OF PROVIDER OR SUPPLIER EAGLE CREEK HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 4102 SHORE DR INDIANAPOLIS, IN 46254			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1. upleted on May 4, 2018.				
F 0812 SS=F Bldg. 00	§483.60(i) Food s The facility must - §483.60(i)(1) - Pro	e/Prepare/Serve-Sanitary afety requirements. Docure food from sources idered satisfactory by				
	federal, state or lot (i) This may included directly from local applicable State as regulations. (ii) This provision facilities from using gardens, subject to applicable safe graphicable safe gractices. (iii) This provision	ocal authorities. de food items obtained producers, subject to				
		ore, prepare, distribute and ordance with professional service safety.	F 0812	F 812		05/24/2018
	Based on observation	on, interview, and record	1.0017	1 012		U3/24/2010

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

review the facility failed to ensure dishes were

sanitizing temperature levels. These practices had

clean, the dishwasher wash cycle achieved

Event ID:

NTDN11

Facility ID: 010666

Corrective actions

accomplished for those

residents found to be affected

If continuation sheet

Page 2 of 6

06/07/2018 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155664 B. WING 04/24/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4102 SHORE DR EAGLE CREEK HEALTHCARE CENTER INDIANAPOLIS, IN 46254 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the potential to effect 90 of 97 residents, who were by the alleged deficient served meals from the kitchen. practice: All residents have the potential to be affected by this Findings include: alleged deficient practice. Identification of other residents 1a. During a dining observation on 4/16/18 at having the potential to be 11:55 a.m., LPN (Licensed Practical Nurse) 5 was affected by the same alleged observed serving soup to residents, from a cart deficient practice and with a crock of soup on top of it. She picked up corrective actions taken: All each of the bowls by the rim, with her thumb residents have the potential to be inside each bowl, and served soup to 14 affected by this alleged deficient unidentified residents. practice. The Dietary Manager or designee will observe the following 1b. At 12:05 p.m., LPN 5 returned 6 soup bowls to to ensure compliance: the kitchen, and brought out another stack of 1). Observe dishwasher as it is bowls and placed them on the serving cart. running through its cycle. Check temps for wash and rinse to During an interview at 12:12 p.m., LPN 5 indicated ensure they are at the appropriate the bowls she returned were dirty, they contained sanitizing temperatures dry, crusted food particles. 2). Observe to ensure temp logs of dishwasher wash and rinse are 2. During an observation of the kitchen being kept per policy dishwasher on 4/16/18 at 10:24 a.m., the wash 3). Observe to ensure all staff temperature was 147 degrees Fahrenheit (F) and members in the kitchen (include the rinse temperature was 170 degrees F. those coming in to get ice) have appropriate hair and beard nets in During an observation of the dishwasher on place 4/16/18 at 10:26 a.m., the wash temperature was 4). Observe staff to ensure 140 degrees F. and the rinse temperature was 184 appropriate handwashing degrees F. techniques are being used 5). Observe dry storage areas to During an observation of the dishwasher on ensure all packaged and canned 4/16/18 at 10:28 a.m., the wash temperature was items are properly sealed and 140 degrees F. and the rinse temperature was 190 dated degrees F. 6). Observe staff serving (including

During an observation of the dishwasher on

4/16/18 at 10:30 a.m., the wash temperature was

138 degrees F. The (kitchen) Account Manager (AM) placed a T-stick (cardboard meat

soup) to ensure their fingers are

inside of the bowls and glasses

not touching the brims or the

06/07/2018 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155664 B. WING 04/24/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4102 SHORE DR EAGLE CREEK HEALTHCARE CENTER INDIANAPOLIS, IN 46254 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE thermometer) in the dish rack and ran it through Measures put in place and the dishwasher. The AM indicated as long as the systemic changes made to T-stick turned black, he was satisfied the dishes ensure the alleged deficient were sanitized. practice does not recur: Dietary Manager or designee will During an interview on 4/16/18 at 10:39 a.m., the re-educate the dietary staff on the AM indicated the fan usually froze-up and caused following policies: 1). Specification condensation, and he pointed to areas of Information - Wash temperature condensation on the dishwasher. (hot water sanitizing) 160 degrees F. Rinse temperature (hot water During an interview on 4/16/18 at 10:43 a.m.. sanitizing) 180 degrees F 2). Dietary aide 26 indicated the dishes were usually Ware washing (cleaning of dirty run through the dishwasher twice. kitchen ware) - all dish machine water temperatures will be During an interview on 4/16/18 at 1:45 p.m., the maintained in accordance with Route Manager from (name of dishwasher repair manufacturer recommendations for company) indicated the facility had good exhaust high temperature or low that lowered the wash temperature, the longer the temperature machines 3). Food dishwasher was used, the cooler the wash water Storage: Dry Goods - all packaged would become because cooler water was running and canned items will be kept in, and the dishwasher did not have the vent clean, dry and properly sealed and baffling to prevent the temperature from dropping date marked as appropriate below 160 degrees F. The Dietary Manager or designee During an interview on 4/23/18 at 2:31 p.m., the will re-educate the facility staff on AM indicated the dishes should have been the following: 1). Staff Attire - all washed at the manufacturer's wash staff members will have their hair recommendation of 160 degrees F. and the dishes off their shoulders, confined in a sometimes needed to be run through the hair net or cap and facial hair dishwasher 2 - 3 times to be cleaned. properly restrained. 2). Food: Preparation - all staff will practice

A document, titled, "Section 1: Specification Information," with no date, was provided by the Administrator on 4/19/18 at 10:55 a.m. The information for the facility dishwasher was, " ...Water Requirements (All Models), ...Wash Temperature (hot water sanitizing) 160 degrees F., Rinse Temperature (hot water sanitizing) 180 degrees F ... " and " ... Note: For ventilation

systems that connect directly to the conveyor, it

How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits /

proper hand washing techniques.

The proper way to wash your

hands - wash hands while

If continuation sheet

counting to 20

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

PRINTED: 06/07/2018 FORM APPROVED OMB NO. 0938-039

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NAME OF PROVIDER OR SUPPLIER EAGLE CREEK HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 4102 SHORE DR INDIANAPOLIS, IN 46254				
	SUMMARY (EACH DEFICIENT REGULATORY OF ITS	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION To use baffled ventilation scoops trol of the airflow out of the "Healthcare Services Group, aning of dirty kitchen ware) 017, was provided by the /19/18 at 10:12 a.m. It indicated, we water temperatures will be ance with manufacturer or high temperature or low	4102 S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) observations will be conducte the Dietary Manager or design times per week times 8 weeks then monthly times 4 months ensure compliance:). Observe dishwasher as it is running through its cycle. Che temps for wash and rinse to ensure they are at the appropriate sanitizing temperatures 2). Observe to ensure temp to dishwasher wash and rinse are being kept per policy 3). Observe to ensure all staff members in the kitchen (incluithose coming in to get ice) has appropriate hair and beard ne place 4). Observe staff to ensure appropriate handwashing techniques are being used 5). Observe dry storage areas ensure all packaged and canritems are properly sealed and dated	d by nee 2 s, to seck rriate ogs of re de ve ets in		
				6). Observe staff serving (incl soup) to ensure their fingers a not touching the brims or the inside of the bowls and glasse. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quasurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	are es		

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

Event ID:

NTDN11

Facility ID: 010666

If continuation sheet

Page 5 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/07/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							B NO. 0938-039
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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155664	B. WING			04/24/2018	
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(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	=	DATE
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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NTDN11 Facility ID: 010666 Page 6 of 6 If continuation sheet