| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00318324, IN00319404, and IN00319922.<br><br>Complaint IN00318324 - Substantiated. Federal deficiencies related to the allegations are cited at F740.<br>Complaint IN00319404 - Unsubstantiated due to lack of evidence.<br>Complaint IN00319922 - Unsubstantiated due to lack of evidence.<br><br>Survey dates: February 16, 17, 18, and 19, 2020<br><br>Facility number: 010666<br>Provider number: 155664<br>AIM number: 200229930<br><br>Census Bed Type:<br>SNF/NF: 83<br>Total: 83<br><br>Census Payor Type:<br>Medicare: 6<br>Medicaid: 69<br>Other: 8<br>Total: 83<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on February 27, 2020. | F 0000 | | |
| F 0740<br>SS=E<br>Bldg. 00 | 483.40<br>Behavioral Health Services<br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health | | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br>Based on observation, record review, and interview, the facility failed to ensure a system for assessment, reporting, documentation, and management of residents with known behaviors for 7 of 7 residents reviewed for behaviors (Residents E, H, K, L, F, G, and J).<br><br>Findings include:<br><br>A confidential interview during the survey indicated, the facility had turned into a "dope house and alcohol place." Management had to go to the local carry out around the corner and tell them not to sell alcohol to the residents. Residents were outside peeing on the building, drinking, and smoking dope.<br><br>A confidential interview during the survey indicated, there were several residents believed to have been drinking especially on the weekends, as evidenced by smelling alcohol on their breath. Residents would walk to the liquor store and share alcohol with their peers. Alcohol had been found in the past hidden in the bushes outside where residents smoked. Residents suspected or known to have been drinking alcohol on facility property included Resident E, Resident F, Resident G, and Resident H. Residents that had smelled of alcohol and marijuana included, Resident J, and Resident K, who was also suspected of going on liquor runs. There were | F 0740 | 1. Residents E, H, K, L, F, G, and J remained confidential and were part of a confidential complaint survey.<br><br>2. All residents have the potential to be affected by the deficient practice.<br><br>An audit has been completed on all residents to ensure an accurate assessment of the resident has been completed.<br><br>Residents that are identified as wishing to smoke while residing in the facility have had an audit completed to ensure they have a smoking assessment, a plan of care in place, have been educated on the smoking policy, and have signed the facility smoking policy. A current list of smokers has been updated and made available to staff.<br><br>Residents that have had a fall in the last 30 days have had an audit completed to ensure the appropriate assessments were completed and the plan of care | 03/20/2020 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | multiple residents that went out to smoke cigarettes. But there was no smoking list available at the nurse's stations. There were smoking times, but staff did not always have time to take residents out so they either went out independently or not at all during the busy times of the shift. Staff kept an eye on residents and tried to confiscate alcohol bottles as they were smuggled into the facility.<br><br>A confidential interview during the survey indicated, the previous weekend a visitor had come into the facility and reported there was a smell of marijuana out where the residents were smoking. Staff were unable to determine who was smoking the marijuana, so the residents were all told to stop it. A night nurse had recently caught Resident H, Resident L, and another resident smoking marijuana. The nurse called the physician and was given orders to hold the residents' narcotic medications. This made the residents mad, and Resident L had left the facility AMA. A nurse had also confiscated a bottle of alcohol from Resident H and placed it in the medication room. Management had been made aware.<br><br>A confidential interview during the survey indicated, residents were supposed to sign out when they went outside to smoke. There was not a list of residents that smoked at the nurse's station. Staff monitored the residents as best they could, and if a resident was thought to be intoxicated the physician was notified, orders were obtained to hold their medications, a room search was done by administration, and liquor was confiscated which upset the residents. Social Service would talk with residents and tell them alcohol was not allowed. Not sure how the residents were getting liquor and marijuana but it could be smelled on them. Administration knew of | | was updated. Those found to not be in compliance with an accurate assessment will be reviewed, MD notified, family notified, and new interventions will be added to the plan of care to ensure the safety of the residents.<br><br>Residents with known behaviors have been audited and a plan of care has been implemented, behavior management has been added to their medical record, those that are identified as having a present/past history of illicit drug/alcohol use have been educated and signed the facility policy as it relates to illicit drug/alcohol use.<br><br>An audit was completed of all residents' documentation for the past 30 days to ensure further follow-up was completed as needed. Those found to need further follow up had their documentation, notification, orders, and plan of care updated accordingly.<br><br>3. The SDC/designee has in-serviced all staff on the facility smoking, illicit drug, and alcohol policy.<br><br>The SDC/designee has in-serviced all staff on the behavior management program with emphasis on reporting and documenting behaviors. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | the issues with alcohol and marijuana issues. These issues were handled in house so not sure how much documentation could be found in the residents' medical record. Several residents with known alcohol related behaviors had been transferred out. Residents suspected or known to have been drinking alcohol on facility property included Resident H, Resident G, Resident F, and Resident E.<br><br>1. During an observation of Resident E, on 2/17/2020 at 2:25 p.m., the resident was sitting on the side of the bed watching television and eating lunch. The resident was alert, talkative, and indicated staff had spoken with her in the past regarding drinking alcohol but she didn't drink anymore.<br><br>During an observation of Resident E, on 2/17/2020 at 2:35 p.m., the resident was propelling independently down the hallway in a wheelchair, and indicated she was going outside to smoke. The resident was observed to have smoking materials without stopping at the nurse's desk.<br><br>Record review was completed for Resident E on 2/17/2020 at 9:30 a.m. The record indicated, Resident E's diagnoses included, but were not limited to, alcoholic cirrhosis of the liver, epilepsy, and psychoactive substance abuse.<br><br>Physician's orders for Resident E, dated 12/1/19 - 2/16/2020, indicated there was no order for alcoholic beverages.<br><br>A Social Service Progress Note for Resident E, dated 1/25/2020 at 8:30 p.m., indicated the resident stated the nurse found alcohol in her possession in her walker pouch. The resident articulated she | | The SDC/designee has in-serviced all staff on the expectation of reporting events/incidents to the appropriate supervisor with emphasis on reporting all events/incidents to the facility administer and director of nursing.<br><br>The SDC/designee has in-serviced all licensed staff on documentation in the medical record with emphasis on documentation of event/incidents, including but not limited to falls, illicit drug use, and alcohol use.<br><br>The SDC/designee has in-serviced all licensed staff on completing, reporting, and documenting assessments in the medical record with emphasis on falls and smoking.<br><br>The SDC/designee has in-serviced the social service director and designee on the behavior management program with emphasis on ensuring the patient has an accurate plan of care with appropriate interventions to meet the needs of the patient.<br><br>4. The DON/designee will audit all new admissions for 1 month, then 15 admissions x 2 months, then 10 admissions x 3 months to ensure appropriate behavior management, plan of care, education, and documentation has | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | was aware of the facility policy, and that she had broken the facility policy.<br><br>An electronic physician service progress note for Resident E, dated 1/28/2020 at 3:21 a.m., indicated a physician had been paged by the nurse after the resident had a fall. Documentation indicated staff was to follow fall protocol.<br><br>A Progress Note for Resident E, dated 1/28/2020 at 5:28 a.m., indicated the resident reported she had rolled from her bed to the floor. The physician was made aware using the electronic physician service.<br><br>An Occurrence Log, dated 12/1/19 - 2/18/2020, indicated there was no documentation of the resident having fallen on 1/27/2020.<br><br>A Fall Assessment for Resident E, dated 1/27/2020, indicated the resident fell out of bed.<br><br>Review of Resident E's electronic medical record, and the Social Service smoking binder indicated, lacked documentation regarding review of the facility smoking policy, a physician's order to smoke, a smoking assessment having been completed, or a smoking care plan.<br><br>A Physician's Progress Note for Resident E, dated 1/13/2020, indicated the resident was an every day smoker. The resident had been advised to quit smoking due to a cough. Smoking and tobacco use cessation counseling were performed during the visit.<br><br>A Nurse Practitioner Note for Resident E, dated 1/13/2020, indicated the resident presented with no recently noted behaviors or worsening signs or symptoms of psychiatric diagnoses. | | been initiated on residents identified with a past/present history of smoking, illicit drug, and/or alcohol use.<br><br>The DON/designee will read the facility 24/72 hour report Monday-Friday to ensure all appropriate reporting and documentation is completed. The weekend supervisor will read the 24 hour report on Saturday and Sundays. This will be an on-going facility practice.<br><br>The DON/SSD/designee will audit 10 smokers weekly x 1 month, then 5 smokers weekly x 2 months, then 10 smokers monthly x 3 months to ensure that each resident has been educated on the smoking policy, signed the policy, an assessment has been completed, and an accurate plan of care was implemented.<br><br>The DON/designee will audit all residents that have a fall Monday-Friday and the weekend supervisor will audit the falls on Saturday and Sunday to ensure an accurate assessment is completed, all other required documentation is completed, and the plan of care is updated with appropriate interventions. This will be an on-going facility process.<br><br>The results of the audit will be reported, reviewed, and trended for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | The quarterly MDS (Minimum Data Set) assessment, completed on 2/3/2020, assessed Resident E as having the ability to make herself understood and to understand others. Brief Interview for Mental Status (BIMS) score of 9 indicated moderately impaired cognition. There were no signs or symptoms of delirium, behaviors, rejection of care, or wandering. The resident required extensive assistance of 1 person for bed mobility and transfers, walking in corridor, and locomotion on unit. Supervision of 1 person for walking in room, and locomotion off the unit. Mobility devices included a wheelchair. Resident had falls since admission to include 1 falls since the last assessment.<br><br>Review of care plans for Resident E indicated, there was no care plan regarding alcohol use on facility property or the resident having been found with alcohol in her possession. A fall care plan for Resident E indicated, there were no new interventions added after having fallen on 1/27/2020.<br><br>During an interview on 2/18/2020 at 12:58 p.m., Nurse Practitioner (NP) 17 indicated, Resident E had a real drinking problem, and the husband had been told to not visit in the past due to bringing alcohol. When the resident was observed during the day she would deny drinking, and as she "looked good" there was nothing the NP could do about "hearsay."<br><br>2. During an observation of Resident H, on 2/16/2020 at 6:35 p.m., the resident was lying in bed, with the lights off, and a large amount of personal items stacked around the bed. The resident indicated, she performed her own activities of daily living with assistance of the | | compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | staff, and she went outside to smoke independently without supervision.<br><br>A bottle of vodka was observed in the 200 hallway medication room on 2/12/2020 at 4:21 p.m., with Resident H's name written on the bottle in red marker. Licensed Practical Nurse (LPN) 9 indicated, the bottle had been found in the resident's possession and confiscated.<br><br>On 2/16/2020 at 7:30 p.m., Resident H was propelling herself down the hallway. The resident indicated to staff she was going outside to smoke. The resident was not observed to stop at the nurse's station to retrieve smoking materials. There were no staff members observed outside.<br><br>During an observation on 2/19/19 at 7:30 a.m., Resident H propelled herself outside to smoke near the front entrance. Employees had been observed exiting the parking lot on foot, walking over a slight grassy hill towards multiple stores, to include a liquor store and all night convenience store that could be observed from the entrance and parking lot of the facility.<br><br>During an observation on 2/19/2020 at 8:11 a.m., Resident H entered her room and requested pain medication. The resident indicated she had been outside by herself smoking without peers or staff. She went out all the time with no one else out with her and she didn't mind.<br><br>A record review was completed for Resident H on 2/17/2020 at 10:40 a.m. The record indicated, Resident H's diagnoses included, but were not limited to, alcohol use and repeated falls.<br><br>A Smoking Assessment for Resident H, dated 12/23/19, indicated the resident required 1 on 1 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | assistance for smoking. A smoking care plan, dated 9/3/19, indicated the resident had been assessed as an independent smoker.<br><br>A progress note, dated 12/7/2019 at 2:48 p.m., indicated staff was alerted by an unidentified resident that Resident H was outside on the ground. Upon arrival outside the resident was observed by the nurse to be in a sitting position on the ground, and smoking a cigarette. The resident stated that she was sitting on another resident lap when she slid out on to the ground.<br><br>An electronic physician service progress note for Resident H, dated 12/7/19 at 3:22 p.m., indicated a physician was notified "the resident went outside with her IV pole, was sitting in another patient's lap and slid down to the ground. It appears patient may have been drinking as well. Recommend holding her pain medications until she can sober up."<br><br>An interdisciplinary team (IDT) note for Resident H, dated 12/9/2019 at 5:55 p.m., indicated the resident had a witnessed fall outside when she was sitting on the lap of another resident and leaned forward and fell. IDT felt the root cause for the fall was related to resident sitting on another resident's lap. New intervention was for resident to sit in wheelchair at all times when outside smoking.<br><br>An electronic physician service progress note for Resident H, dated 12/21/19 at 7:07 p.m., indicated a physician was notified "Resident had a fall with no injuries. Meds held due to patient appearing intoxicated and smelling of liquor."<br><br>A progress note for Resident H, dated 12/21/2019 at 10:31 p.m., indicated an unidentified resident | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | reported Resident H had fallen outside and a bottle of alcohol was taken from her. The NP was made aware and an order received to hold medications for the evening shift.<br><br>A progress note for Resident H, dated 12/23/2019 at 2:07 p.m., indicated the resident was reassessed for smoking privileges and based on her consistent inability to follow the alcohol policy and smoking policy, it has been determined at that time the resident would need to have her smoking supervised and she must adhere to the smoking times posted.<br><br>A progress note for Resident H, dated 1/24/2020 at 10:40 p.m., indicated the resident returned from outside from outside leave of absence (LOA) and had an alcohol smell upon approach. A water bottle was given on request to the nurse in charge. The NP was notified and meds were held for 24 hours.<br><br>A progress note for Resident H, dated 1/25/2020 at 3:37 p.m., indicated the nurse went in to search Resident H's room for alcohol, after confiscating alcohol from another unidentified resident whom identified Resident H as having provided the liquor for the other resident. Nurse found 3 empty pint bottles of vodka. Approximately 90 minutes later an unidentified resident from the 100 hallway was observed going in to bring something into Resident H's room, and the nurse entered the room to find a full bottle of vodka beneath Resident H's pillow. The vodka was taken, the NP notified, and orders received to hold medications for 24 hours.<br><br>A physician's order for Resident H, dated 1/25/2020 at 10:00 p.m., indicated to hold medications for 1 day every shift for intoxication. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A Social Service (SS) progress note for Resident H, dated 1/25/2020 at 7:14 p.m., indicated she was following up after nursing staff reported alcohol was found in the resident's room. The resident was aware of the facilities alcohol policy, and acknowledges having possession of alcohol.<br><br>Review of Resident H's electronic medical record, and the Social Service smoking binder indicated, there was no documentation regarding re-education of the facility smoking policy, or a physician's order to smoke.<br><br>A review of physician's orders for Resident H, dated 12/1/19 - 2/16/2020, indicated there were no orders for alcohol consumption, no order to hold medications after having been found drinking on 12/7/19, and no order for behavior tracking.<br><br>A Physician's Progress Note for Resident H, dated 2/3/2020, indicated the resident was an every day smoker. The resident had been advised to quit smoking due to a cough. Smoking and tobacco use cessation counseling were performed during the visit.<br><br>A Nurse Practitioner Note for Resident H, dated 1/28/2020, indicated talked to the resident about decreasing Norco (narcotic pain reliever) as patient had been seen drinking recently and meds were always held when this occurred. Patient still smokes several times per day, offered a nicotine patch and she refused.<br><br>A review of care plans for Resident H indicated, there was a fall care plan updated on 12/7/19 to include sitting in her wheel chair while smoking. There was no update to the care plan after the fall on 12/21/19 or documentation of alcohol being a | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | factor during her falls.<br>There was no care plans regarding behaviors. A care plan for history of substance abuse, dated 9/6/19, had not been updated regarding current use of alcohol, goals or interventions.<br><br>3. On 2/17/2020 at 2:20 p.m., Resident K was not observed in his room, the therapist indicated he was most likely outside smoking.<br><br>A record review was completed for Resident K on 2/18/2020 at 9:30 a.m. The record indicated, Resident K's diagnoses included, but were not limited to, alcohol dependence and opioid use.<br><br>Physician's orders for Resident K, dated 12/9/19, indicated, "Behavior Monitoring - Antidepressant: Document Number of Episodes per shift of target behavior [SPECIFY] 1. anxiety 2. insomnia 3. Agitation every shift for Behavior Monitoring." There was no physician's order for alcohol consumption.<br><br>A Progress Note for Resident K, dated 12/18/2019 at 5:31 p.m., indicated the resident reported he had fallen out of the bed the night before and forgot to report it to the night nurse. The resident complained of pain in the right hand, and an order for x-rays was obtained.<br><br>A late entry Progress Note for Resident K, dated 12/19/19 at 10:04 a.m., indicated, Fall IDT for fall on 12/17/19. The resident reported to the staff on 12/18/19 he had fallen the night before when he stated he slid out of bed. Resident stated he did not hit his head but stated he hurt his right hand. He stated he wasn't sure he was fully awake before trying to get up out of the bed and go to toilet. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A Progress Note for Resident K, dated 12/23/2019 at 8:07 a.m., indicated the resident reported he had rolled out of bed during the night.<br><br>A Progress Note for Resident K, dated 12/25/2019 at 5:00 p.m., indicated the resident reported he was outside going down a slope to get some sun, when his wheel chair slid and he fell out of the wheel chair. There was pain to the left side upon falling, but had stopped.<br><br>A Social Service Progress Note for Resident K, dated 1/25/2020 at 8:42 p.m., indicated nursing staff reported the resident had empty alcohol containers found in his room. When addressed the resident denied having any alcohol in his room and was aware of the facilities policy.<br><br>A Progress Note for Resident K, dated 2/12/2020 at 8:32 p.m., indicated the resident was found by Security outside the building "smoking weed." The NP was notified and a new order was received to hold narcotics for 4 hours.<br><br>The quarterly MDS (Minimum Data Set) assessment, completed on 1/15/2020, assessed Resident K as having the ability to make herself understood and to understand others. A Brief Interview for Mental Status (BIMS) score of 14 indicated the resident was cognitively intact. Resident K had no signs or symptoms of delirium, behaviors, or wandering. Resident K had rejection of care 1 to 3 times during the assessment period. The resident required limited assistance of 1 staff for bed mobility. The resident was independent with transfers, walking in room and corridor, and locomotion on and off the unit. The resident had no mobility devices, and 2 or more falls since the prior assessment. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A fall care plan for Resident K, dated 11/19/19, indicated the resident was at risk for falls. On 12/20/19 the care plan was updated to include the intervention of calling for assistance at night for assistance to and from the toilet. There was no care plan regarding behaviors, alcohol abuse, or smoking marijuana.<br><br>4. A record review was completed for Resident L on 2/17/2020 at 11:25 a.m. The record indicated, Resident L's diagnoses included, but were not limited to, alcohol use.<br><br>An Admission MDS assessment, completed on 1/24/2020, assessed Resident L as having the ability to make himself understood and to understand others. A Brief Interview for Mental Status (BIMS) score of 13 indicated he was cognitively intact. The resident had no signs or symptoms of delirium, behaviors, rejection of care, or wandering. The resident required an extensive assistance of 2 or more for bed mobility. The resident required an extensive assistance of 1 for transfers, walking in room and corridor, locomotion on and off the unit. Mobility devices included a walker and wheelchair. The resident used Tobacco and had no history of falls.<br><br>Physician's orders for Resident L, dated 2/12/2020 at 8:45 p.m., indicated hold narcotics for 4 hours one time only until 02/13/2020.<br><br>A Progress Note for Resident L, dated 2/12/2020 at 8:32 p.m., indicated the resident was observed by Security outside the building "smoking weed." The NP was notified and a new order were received to hold narcotics for 4 hours.<br><br>A Progress Note for Resident L, dated 2/12/2020 at 10:55 p.m., indicated the resident was caught | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | outside smoking with other patients. Upper management was aware and the physician notified.<br><br>A Progress Note for Resident L, dated 2/14/2020 at 12:30 a.m., indicated the resident was not in his room at the beginning of the shift, and all his belongings were no longer in the room. The resident was not reachable by phone.<br><br>Review of Resident L's electronic medical record, and the Social Service smoking binder indicated, there was no documentation regarding review of the facility smoking policy, a physician's order to smoke, a smoking assessment having been completed, a smoking care plan, behaviors to include drinking alcohol and smoking marijuana on facility property, or refusal of care.<br><br>During an interview on 2/18/2020 at 12:50 p.m., NP 17 indicated Resident L had a background of alcohol and substance abuse. She was not sure why he left against medical advices (AMA), but if staff reported he had his medications held, he most likely left because he was doing something he shouldn't have.<br><br>5. During an observation on 2/17/2020 at 2:33 p.m., Resident F was observed sitting on his rollator speaking with a visitor.<br><br>During an observation and interview on 2/17/2020 at 2:37 p.m., Resident F was alert and talkative, indicated he had not had anyone speak to him about drinking alcohol in the facility.<br><br>A record review was completed for Resident F on 2/18/2020 at 11:30 a.m. Resident F's diagnoses included, but were not limited to, chronic heart failure, and acute and chronic respiratory failure. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A review of physician's orders for Resident F, dated 12/1/19 - 2/16/2020, indicated there were no order for alcohol consumption.<br><br>Progress notes, dated 12/1/1919 - 2/18/2020, indicated the resident spent large amounts of times outside in inclement weather, and refused to cease smoking despite educations. There was no documentation to indicate the resident was drinking alcohol on facility grounds.<br><br>Fall care plans for Resident F had no documentation to indicate updated interventions were added after falls had occurred on 1/7/2020, 2/6/2020, or 2/13/2020.<br><br>6. During an observation and interview on 2/17/2020 at 2:31 p.m., Resident G was sitting at bedside in his wheel chair watching television. He was alert and talkative, and indicated he had not had any conversations with staff regarding drinking alcohol on the facility property.<br><br>During an observation on 2/19/2020 at 10:45 a.m., Resident G was going outside with a peer to smoke. Resident G was not observed stopping at the nurse's desk to retrieve smoking materials.<br><br>A record review was completed for Resident G on 2/18/2020 at 11:45 a.m. Resident G's diagnoses included, but were not limited to, osteomyelitis of vertebra (inflammation of the bone caused by infection), need for assistance with mobility, and solitary pulmonary nodule.<br><br>A review of Resident G's Progress Notes, dated 12/1/19 - 2/17/2020, indicated the resident had no documentation of drinking alcohol on facility property. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 7. During an observation on 2/19/2020 at 7:45 a.m., Resident J sat in her doorway waiting on her morning medications. The resident was quiet and polite to the nurse.<br><br>A record review was completed for Resident J on 2/18/2020 at 12:05 p.m. Resident J's diagnoses included, but were not limited to, opioid dependence, tobacco use, and bipolar disorder.<br><br>A review of Resident J's Progress Notes, dated 12/1/19 - 2/17/2020, indicated the resident had no documentation of drinking alcohol on facility property.<br><br>Quality Assurance Performance Improvement (QAPI) Meeting Agenda and Minutes, dated 12/16/19 and 1/20/2020 had no documentation to indicate incidents of residents drinking alcohol and/or smoking marijuana on the facility grounds was being addressed.<br><br>During an interview the NP 17 on 2/18/2020 at 12:41 p.m., she indicated she was not in the facility all of the time, but would occasionally get calls that Resident H or other residents had been drinking, and she would give orders to hold their pain meds. When a conversation had taken place between a previous Director of Nursing (DON), previous unit manager, NP 17, and Resident H, the resident had indicated she would be given empty alcohol bottles from other residents at times and she was just throwing them away. Urine screens were ordered if a resident was suspected of smoking marijuana. Last fall the prior DON had called the local liquor store and requested residents not be sold liquor or to call the DON and report. NP 17 indicated, she would not give an order for alcohol to a resident with a diagnosis of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | alcoholism, but it was hard to stop residents from drinking as it was their right to go LOA after signing out.<br><br>During an interview with LPN 15 on 2/19/2020 at 8:25 a.m., he indicated there was no list of residents that smoked at the nurse's desk to his knowledge.<br><br>During an interview with LPN 19 on 2/19/2020 at 8:29 a.m., she indicated there was no list of residents that smoked at the nurse's desk to her knowledge. Management was responsible for updating care plans.<br><br>During an interview on 2/19/2020 at 9:30 a.m., the Social Service Director (SSD) indicated nurses helped with care plans. Upon admission residents would be given and signed the smoking policy by nursing or the admissions department. SSD got involved later if there was a behavior, and she would the resident re-sign the smoking or drinking policies. When a resident was breaking the smoking policy, there should have been a care plan for behaviors. There was a binder in the SS office that had copies of smoking policy forms of those that had been re-addressed for non-compliance and breaking the policy. SSD had not documented on residents drinking alcohol or smoking marijuana as they were "rumors" to her as she had not personally witnessed the behavior and had no definite knowledge of it occurring. She had heard rumors of drinking alcohol and smoking marijuana on the facility property, and had heard there were empty alcohol containers in resident rooms, but it was still a "rumor." Whoever witnessed the incidents should have addressed it and documented, it was important to hold medications. The SSD had not followed up with the resident or documented on alcohol or | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | marijuana use by residents as she didn't "see it." SSD had not care planned any resident for alcohol or drug use.<br><br>During an interview on 2/19/2020 at 9:21 a.m., the Administrator indicated she had smelled marijuana at times but could not track down who was doing it. If a resident was found smoking marijuana it should have been addressed at the time related to medications. It came down to finding the person. If a resident was found with alcohol it was to be confiscated, the resident should have been assessed by the nurse to see if there appeared to be issues, and the physician called for orders. Care plans were updated by the nurses and SS depending on the issue. Resident L had an incident with marijuana and the physician was notified with orders to hold his medications. A few days later Resident L left the facility AMA, but she not sure of the actual reason.<br><br>During an interview on 2/19/2020 at 9:32 a.m., the DON indicated care plans were an IDT effort. She had been updating fall care plans with incidents. Smoking assessments were completed upon admission by nurses or SS. The DON had not heard or been aware of residents being intoxicated in her 2 weeks of employment. If there was an incident of a resident smoking marijuana staff were to notify the physician, hold medications, document, there would not be labs ordered. If there was an issue of residents drinking alcohol and smoking marijuana, it was an IDT approach of nurses monitoring the residents, SS addressing the behaviors, and communication to all departments to help.<br><br>During an interview with the Regions Director of Clinical Operations on 2/19/2020 at 9:35 a.m., she indicated if there was a report of a resident being | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | impaired, or having a substance on them, the nurse was to contact the physician for holding of medications or labs. These issues should have been care planned.<br><br>During an interview with Registered Nurse (RN) 13 indicated, to her knowledge RN 11 had reported residents being impaired to the physician.<br><br>During an interview with RN 11 on 2/19/2020 at 10:14 a.m., she indicated, there had been a couple of times the residents had come in the facility drunk. Once instance was Resident H being caught coming in with alcohol, she was in the room with Resident E at the time. Resident H had indicated, Resident E's husband was leaving the alcohol outside in the bushes in plastic water bottles to disguise it, and residents were getting their alcohol from Resident E's husband. Other nurses would tell RN 11 they thought residents were drunk or they could smell alcohol, and she had told them to call the doctor. RN 11 indicated, she would document in progress notes, and administration was aware. A lot of the offenders had been discharged. Thought there was a security person working 6:00 p.m. - 6:00 a.m.<br><br>On 2/19/2020 at 12:20 p.m., the Administrator provided the Alcoholic Beverage Dispensing policy, dated 5/29/2019, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of this facility to promote resident centered care by providing a method of safe alcoholic beverage dispensing if appropriate. Alcohol will be dispensed by a nursing using the same procedure as a medication. Procedure: 1. Physician's order must be obtained to dispense alcohol to a resident/patient. 2. The amount, type [beer, wine, liquor] and frequency must be specified on order. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 3. The alcohol will be kept in a secured location when not in use. 4. The nurse will dispense the proper amount to the resident as ordered and documented on the MAR [Medication Administration Record] ...."<br><br>On 2/19/2020 at 12:20 p.m., the Administrator provided the Resident Illegal Drug Possession in the facility policy, dated 7/22/16, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...2. A facility may admit a resident who has a history or diagnosis of substance abuse. 3. Residents are not permitted to have any illicit substance or drug-related paraphernalia in their possession while a resident in the family. Procedure: 1. Inform residents and/or their responsible party of the Substance Abuse policy upon admission. 2. Provide a 30 day notice of discharge to the resident/responsible party in the event a resident is found to be under the influence of drugs/substances or is in possession of drug paraphernalia. 3. Notify the ED/DON immediately in the event a resident is suspected of having or possessing illicit/illegal substances or drug paraphernalia on their person, room or otherwise in the vicinity of themselves during their stay or appears under the influence of drugs. a. Secure the safety of other residents by removing them from the area. b. Contact the local police department, physician and responsible party. c. Remain with the resident until police or transport arrives. i. Transport the resident to the acute care facility for suspicion of intoxication or under the influence of illicit drugs ...e. Any resident found to be under the influence or found to have illegal substance paraphernalia will receive a notice of discharge from the facility. 4. Document all items including quantity of each and give all drug paraphernalia to the police upon arrival." | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155664 | A. BUILDING 00<br>B. WING | 02/19/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | On 2/19/2020 at 12:20 p.m., the Administrator provided the Resident/Patient Smoking policy, dated 3/25/16, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of this facility to promote resident centered care by providing a safe smoking area for residents/patients that request to smoke and are capable of safe smoking behaviors either independently or with supervision ...1. Assessment, observation and designation of independent or supervised smoker will be made by the IDT team for each resident/patient who requests to smoke in the facility. a. Complete the screen in the electronic medical record system. b. Smoking Assessments for those residents requesting to smoke will be completed or re-evaluated: i. on admission ii. quarterly iii. Any change in clinical condition ...9. Smoking safety instructions for all smokers will include: a. All smoking materials will be maintained by the facility staff and provided to the resident/patient on request ...c. Smoking materials will be returned to the facility staff upon completion of smoking. d. Noncompliance with the smoking policy may lead to discharge notification. e. Supervised smoking will be performed by a staff member ..."<br><br>This Federal tag relates to Complaint IN00318324.<br><br>3.1 -37(a)<br>3.1-43(a)(1) | | | |