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	02/28/2019

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 IN00284670, IN00285523, IN00285755, IN00287438, and IN00288413. Complaint IN00284670 - Substantiated. Federal deficiencies related to the allegations are cited at F558, F694, and F921. Complaint IN00285523 - Unsubstantiated due to lack of evidence. Complaint IN00285755 - Substantiated. Federal deficiency related to the allegations is cited at F558. Complaint IN00287438 - Substantiated. Federal deficiency related to the allegations is cited at F558 Complaint IN00228413. Substantiated. Federal deficiency related to the allegations is cited at F921. Unrelated deficiency is cited at F755 Survey dates: February 25, 26, 27, and 28, 2019. Facility number: 010666 Provider number: 155664 AIM number: 200229930 Census Bed Type: SNF/NF: 80 Total: 80 Census Payor Type: Medicare: 7	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint Survey on February 28, 2019. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Medicaid: 59 Other: 15 Total: 80 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on March 4, 2019.			
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.			
	Based on observation, interview, and record review, the facility failed to provide showers and document shower preferences (Residents B, D, Q, and R) and to provide nursing services for a new admission (Resident E) for 5 of 7 residents reviewed related to accommodation of needs. Findings include: During a confidential interview, from 2/25/19 through 2/28/19, she indicated her family member had not had a shower since the resident's admission into the facility. 1. On 2/25/19 at 3:23 p.m., Resident Q and a visitor called for a nurse to come to her room. The visitor indicated to Licensed Practical Nurse (LPN) 6 the resident was to have showers at least two times weekly and that was not happening. On 2/25/19 at 3:32 p.m., a visitor for Resident Q was observed approaching LPN 6 at the nurse's	F 0558	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident's affected preferences for bathing/showers to be obtained, placed in Point of Care (POC) for documentation, care plan update and validate bathing / showers are being provided. Resident E no longer resides in facility. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: The Director of Nursing or designee will complete the following: 1.All residents bathing / shower	03/27/2019

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	station and inquired if Resident Q had been added to the shower list. The visitor indicated the resident had not had a shower since her visit a week ago when she had last asked that she be added to the list. On 2/26/19 at 9:17 a.m., Resident Q indicated her family member frequently asked the staff about her showers. She wanted them done with staff present for her safety. Review of Resident Q's Admission Minimum Data Set (MDS) assessment indicated it was very important for her to choose between a tub bath, shower, bed bath, or sponge bath. The section on the MDS assessment to indicate bathing preference was not filled out. On 2/27/19 at 11:17 a.m., a review of Resident Q's "Bathing per resident's choice" documentation, dated January and February 2019, lacked documentation to indicate the resident had a shower. 2. Review of Resident D's Admission MDS assessment, dated 12/20/18, indicated it was very important for her to choose between a tub bath, shower, bed bath, or sponge bath. The section on the MDS assessment to indicate bathing preference was not filled out. On 2/27/19 at 11:17 a.m., a review of Resident D's "Bathing per resident's choice" documentation, dated January and February 2019, lacked documentation to indicate the resident had a shower. 3. On 2/26/19 at 11:31 a.m., the family member of Resident B indicated the resident had resided in the facility for a few months, and he had not		preference will be obtained, placed in Point of Care (POC) for documentation, care plan update and validate bathing / showers are being provided 2.All residents admitted or discharged in the last 7 days medical record will be reviewed to ensure nursing services provided for admission / discharge is documented in the assessments / notes and the discharge status is clearly stated. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Director of Nursing or designee will educate on the following: 1. The Nursing staff on the policy for personal care for shower and bathing 2.The Licensed Nurses on the policies for admission evaluation and transfer / discharge related to documentation **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the Director of Nursing or designee: 1. Review of 5 residents 5 times per week for 2 weeks, then 1 times per week for 4 weeks, then monthly for 4 months to ensure	

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	received a shower or anyone to help him take a shower. Review of Resident B's Admission MDS assessment, indicated it was very important for him to choose between a tub bath, shower, bed bath, or sponge bath. The section on the MDS assessment to indicate bathing preference was not filled out. On 2/27/19 at 11:17 a.m., a review of Resident D's "Bathing per resident's choice" documentation, dated January and February 2019 indicated, there was no documentation to indicate the resident had a shower. 4. On 2/26/19 at 8:27 a.m., Resident R indicated she was scheduled for showers on Mondays and Thursdays. Review of Resident R's Admission MDS assessment indicated it was very important for him to choose between a tub bath, shower, bed bath, or sponge bath. The section on the MDS assessment to indicate bathing preferences was not filled out. On 2/27/19 at 11:17 a.m., a review of Resident R's "Bathing per resident's choice" documentation, dated January and February 2019, lacked documentation to indicate the resident had a shower. On 2/27/19 at 11:55 a.m., the Director of Nursing (DON) indicated she could not answer for the lack of documentation for showers. On 2/28/19 at 11:30 a.m., the Regional Director of Clinical Operations indicated there was no additional documentation found to indicate		compliance: review bathing / shower preference to ensure it is listed in POC for documentation, the care plan has been updated and validate the baths / showers are being given. 2.Review the new admissions and discharges to ensure nursing services provided for admission / discharge is documented in the assessments / notes and the discharge status is clearly stated. This process will be ongoing as part of the daily clinical meeting. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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resident preferences for showers had been documented in the medical records for Residents B, D, Q, or R.

On 2/28/19 at 3:30 p.m., the DON indicated she had asked the residents about their bathing preferences, but she did not document the preferences in their clinical record.

On 2/28/19 at 3:32 p.m., the Executive Director (ED) indicated the Activity Director was responsible for filling out the MDS assessments related to preferences and activities for the residents. Resident preferences should have been part of their care plan. Some residents would refuse showers or family members would indicate they had given the resident a shower, but either way information should have been documented and it was not done.

On 2/28/19 at 1:40 p.m., the DON provided a policy, titled, "Personal Bathing and Shower", dated 4/25/18. The policy indicated, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. Residents have the right to choose their schedules, consistent with their interests, assessments, and care plans including choice of personal hygiene. This includes, but is not limited to, choices about the schedules and types of activities for bathing that may include shower, a bed-bath or tub bath, or a combination and on different days ....Bathing preferences should be care planned including type and schedule ....a. Determine resident preference for shower or bathing at bedside. b. Determine resident preference for am or pm personal bathing care. c. Determine resident preference for number of

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	showers during week. d. Care plan resident preference and communicate to staff providing personal care. e. Review preferences during care planning meeting ..." 5. On 2/25/19 at 3:53 p.m., the family member of Resident E indicated the resident was admitted to the facility from the hospital about two weeks ago. He arrived at the facility about 4:00 p.m., and when the family member arrived about an hour later, she could not tell if staff had checked the resident in. Around 8:00 p.m., due to what she perceived as lack of acknowledgement from staff, and failure to provide him with water, she decided to take him home where she thought it would be safer. Record review for Resident E's was completed on 2/27/19 at 3:02 p.m. The record indicated the resident was admitted and discharged on 2/14/19. The resident's diagnoses included, but were not limited to, encounter for prophylactic immunotherapy for respiratory syncytial virus (RSV) and chronic obstructive pulmonary disease (COPD). Review of Resident E's Physician's orders, indicated the following: An order, dated 2/14/19, indicated to monitor oxygen saturations/pulse oximetry every day and night shift for hypoxia and as needed An order, dated 2/14/19, indicated the resident needed oxygen at 3 liters (L)/minute via nasal cannula (NC) with humidification continuously every shift for hypoxia Review of Resident E's "Vital Signs" record lacked documentation to indicated a weight, vital signs, or oxygen saturations had been assessed.			

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Review of "Assessments" for Resident E lacked documentation to indicate any nursing assessments had been completed.

Review of "Progress Notes" for Resident E lacked documentation of any progress notes.

On 2/28/19 at 11:30 a.m., the Regional Director of Clinical Operations indicated the resident should have had an assessment upon admission to include no less than vital signs and respiratory status. Progress notes routinely are made upon admission to indicate the resident had arrived to the facility and status at the time. There was no documentation found in this resident's chart from nurses or any ancillary department during his stay. The staff failed to provide necessary documentation for the resident.

On 2/28/19 at 11:35 a.m., the DON indicated she did not remember the resident. But, upon admission of a resident there were a lot of assessments and documentation to be completed on residents by the nurses. This resident should have had vital signs, and an Admission Nursing Assessment at least started then to be completed within 24 hours. When the resident left against medical advice (AMA) there should have been documentation of his status at the time of discharge, his reasoning for leaving, an AMA form filled out, and documentation the physician had been notified.

On 2/28/19 at 12:11 p.m., the ED indicated the resident came in on 2/14/19 later in the evening, she thought around 5:00 p.m. The ED received a phone call that the resident wanted to go home from the clinical liaison as the family member had called her. The ED called the family member for

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	issues and the family member indicated the nurse had not been in the room yet, and the nurse had an accent and she could not understand him. The ED then called the nurse, who indicated he and aides had attempted to go into the room and the family member would not let them in the room. The family member indicated she was taking him home to get services. The ED acknowledged there was no documentation in the resident record to indicate the resident was admitted to the facility or left AMA. The nurse should have put documentation in the resident record to explain the situation. On 2/28/19 at 12:45 p.m., the Regional Director of Clinical Operations provided a policy, titled "Admission Evaluation", dated 9/21/16. The policy indicated, "It is the policy of this to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. A systematic evaluation is completed by a licensed nurse upon admission/readmission to assist in determining the most effective and appropriate care needs of each resident admitted to the center. Complete the Admit/Readmit/Quarterly Screener assessment and appropriately triggered assessments electronically as soon as feasible but within 24 hours. Prioritize resident needs with appropriate interventions to include but not limited to: a. Meet immediate physical needs including assessment of pain. b. Provide social and emotional support ...e. Provide toileting needs. f. Complete medication reconciliation. g. Consider last meal eaten and provide hydration. 3. Obtain information from the caregiver, family member or significant other if the resident is unwilling or unable to contribute. Make note of the historian in the progress note. Inform physician of the resident care needs ..."			

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	On 2/28/19 at 12:45 p.m., the Regional Director of Clinical Operations provided a policy, titled, "Transfer and Discharge Policy", dated 3/10/17. The policy indicated, "Discharge may be planned or unplanned leave of absence [LOA]; a resident leaving against medical advice [AMA] is considered a discharge with conditions of the policy applicable ...It is the policy of this facility to provide resident centered care that meets the psychosocial physical and emotional needs and concerns of the residents, including a smooth transition of care for discharge or transfer ..." This Federal tag relates to Complaints IN00284670, IN00285755, and IN00287438. 3.1-3(v)(1)			
F 0694 SS=E Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.			
	Based on observation, interview, and record review, the facility failed to maintain a system for the management of antibiotic therapy with the use of peripherally inserted central catheter (PICC) lines for 4 of 4 residents reviewed for PICC line use (Residents B, W, X, and J). Findings include: 1. During a confidential interview, from 2/25/19 through 2/28/19, she indicated Resident B was not getting medications at the right time or the	F 0694	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** PICC line flush orders and dressing change orders are in place for all affected residents. Infectious disease visit progress notes to be obtained for all residents affected and placed in the medical record.	03/27/2019

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	supply of medications had been allowed to run out. She had called the Social Worker and Executive Director (ED) to make an emergency run to pick up medications and the medications were administered six hours late. On 2/26/19 at 8:50 a.m., Resident B was observed propelling himself out of his room in a wheelchair. He had a wound vacuum suction box sitting on his lap, with tubing running to his lower extremity, and a PICC line on his inner left bicep. The resident indicated he had been in the hospital for several weeks, and now in the facility for several weeks related to his wound and need for IV antibiotic therapy. On 2/26/19 at 12:26 p.m., Resident B was observed lying in bed watching television. He indicated the nursing staff had a problem getting his IV's done without him calling to remind them it was due, especially the 10:00 p.m. dose. An empty antibiotic IV bag was observed on an IV pole beside the bed, the pink label on the IV bag was blank, there was no date on the bag, no time the antibiotic had been administered, and no nurse's name to indicate who had hung the bag. The PICC line dressing on the resident's left inner arm was dated 2/16/19 and the resident indicated the dressing had not been changed since his return from the hospital. On 2/27/19 at 10:40 a.m., Resident B was observed lying in bed playing a video game. He indicated the nurse changed his PICC dressing the evening before, and the nurse told him it was due to questions being asked about the dressing change dates. Record review was completed for Resident B on 2/26/19 at 11:50 a.m. The record indicated the		**Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: The Director of Nursing or designee will complete the following: 1.Review all residents with PICC lines to ensure they have flush orders, dressing change orders and validate the current PICC dressing in place has been changed within the past 7 days 2.Review all residents who visit the Infectious Disease MD and ensure the visit notes are obtained timely and placed in the medical record. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Director of Nursing or designee will in-service the Licensed Nurses on the following: 1.Central Venous Access Devices: Site care and dressing change 2.Intermittent Infusion – related to flush The Director of Nursing or designee will in-service the nurse managers on the following: 1.Infectious disease visit progress notes are to be obtained timely for all residents affected and placed in the medical record	

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	resident was re-admitted on 2/16/19, with diagnoses to include, but were not limited to, arthritis due to other bacteria of left foot and ankle, and pyothorax without fistula (presence of inflammatory fluid or pus within the chest cavity). Review of Resident B's Physician's orders indicated the following: -Dated 2/17/19, "Cefepime HCI Solution (antibiotic to treat bacterial infection) reconstituted 2 milligrams (mg), use 1 dose intravenously every 8 hours for antibiotic for 37 days" - Dated 2/17/19, Infectious Disease Clinic follow up at (phone number). Labs weekly to be faxed to the physician. -Dated 2/17/19, non-weight bearing (NWB) to left lower extremity (LLE) at all times. -Dated 2/17/19, wound vacuum to left outer ankle wound to be changed on Monday-Wednesday-Friday The clinical record lacked orders to flush the PICC line or to monitor the PICC line dressing. Review of Resident B's current care plans indicated the "...[Resident]is on Antibiotic therapy related to septic joint ...Goal: [Resident] will be free of any discomfort or adverse side effects of antibiotic therapy ...Interventions: Administer meds as ordered ..." On 2/27/19 at 11:40 a.m., the Director of Nursing (DON) provided a hand written care plan for Resident B. The care plan, dated 2/16/19, indicated, "IV medication, location right arm, dressing change weekly," and the Physician's order for Resident B, dated 2/27/19, indicated change PICC line dressing one time a day every 7 days for IV therapy.		**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the Director of Nursing or designee: 1.Review of all residents with PICC lines 5 times per week for 2 weeks, then 1 times per week for 4 weeks, then monthly for 4 months to ensure compliance: review to ensure they have flush orders, dressing change orders and validate the current PICC dressing in place has been changed within the past 7 days 2.Review of all residents who visit the Infectious Disease MD 2 x per week for 4 weeks then monthly for 5 months to ensure compliance: review to ensure the visit notes are obtained timely and placed in the medical record. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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On 2/27/19 at 11:40 a.m., the DON provided a "Medication Administration Record [MAR]" for Resident B, dated January 2019. The record indicated, "change PICC line dressing to right arm once weekly, discontinue date 2/11/19" and "Medication Administration Record" for Resident B, dated February 2019. The record indicated, "change PICC line dressing to right arm once weekly, discontinue date 2/11/19." The "Medication Administration Record", dated January and February 2019, indicated the resident's Cefazolin IV antibiotic was administered at exactly at 6:00 a.m., 2:00 p.m., and 10:00 p.m. every daily.

On 2/28/19 at 1:25 p.m., the DON indicated, Resident B had been going out to see the Infectious Disease physician for at least a few months. The facility had not acquired copies of notes from the Infectious Disease physician visits.

During an interview, on 2/28/19 3:18 p.m., the DON indicated if a resident came in with a PICC line, the site should be assessed upon admission and then every shift or with problems. There should have been an order for dressing changes, flush orders, and monitoring written on the physician's orders. The Minimum Data Nurse (MDS) would put the orders in a care plan. There was no documentation of the PICC's being monitored and flushed. She felt confident by talking with the residents that it was being done. When an IV antibiotic was administered, it was documented in the MAR by the nurse. The MAR would indicate 6:00 a.m., 2:00 p.m., and 10:00 p.m. daily, as the IV being completed. The system did not indicate the exact time the medication was documented, so the medication could have been administered early or

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late and there was no way of telling when it was actually done. If a PICC line was not flushing or running properly, the nurse should have assessed the problem, and called the physician. If IV antibiotics were missed the physician had to be called. The Unit Managers were responsible for assuring orders were in place for dressing changes and flush orders.

During an interview, on 2/28/19 at 3:26 p.m., the DON indicted when a resident went out to an appointment with the Infectious Disease physician, they were to return with documentation of the appointment, and follow up appointment dates. If the resident did not return with the documentation, and it was not obtained, there was no way of knowing what was going on with the infections. There was not a designated person to follow up to assure documentation was received, but it would be expected the nurse or unit manager would follow up. One resident currently seeing the Infectious Disease physician had not given permission for the facility to have her paperwork, the DON was not sure about the other residents seeing the Infectious Disease physician.

On 2/27/19 at 11:45 a.m., the Executive Director (ED) provided a policy, titled "Central Venous Access Devices: Site Care and Dressing Change", dated 12/2014. The policy indicated, "...The catheter insertion site is a potential entry site for bacteria that may cause a catheter-related infection ...Licensed nurses caring for the residents receiving infusion therapies are expected to follow infection control and safety compliance procedures. Guidance: ...Dressing changes using transparent dressing are performed: a. 24 hrs post-insertion, b. at least weekly, c. if the integrity of the dressing has been compromised..Assessment of venous access site

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is performed: a. During dressing changes. b. Before and after administration of intermittent infusions. c. At least every shift when not in use...Length of external catheter is obtained upon admission ..."

On 2/27/19 at 11:45 a.m., the ED provided a policy, titled "Administration Procedures: Intermittent Infusion Administration", dated 12/2014. The policy indicated "Once a physician's order for intermittent infusion therapy is obtained, the nurse must verify the identity of the patient and ordered medication ....IV tubing should be changed every 24 hours or as per facility policy. A protective sterile cap is to be applied to the distal end of tubing when it is disconnected from patient ...Observed the IV insertion site for any sign/symptom of IV related complications. If any are noted, discontinue IV and restart, according to IV insertion guidelines. Administration of solution is to continue if no IV complications are present. 11. Disinfect valve with alcohol swab, dry, insert 0.9% normal saline solution (NSS) syringe into valve and flush line ...After compilation of infused medication, disconnect tubing from the patient and apply a sterile protective cap to the end. Disinfect the valve with alcohol swab and allow to dry. 16. Insert 0.9% NSS syringe into valve and flush to clear solution from the IV line then disinfect the valve with alcohol swab and allow to dry...Insert syringe with appropriate dose of heparin flush and flush tubing to maintain patency then clamp access device. 18. Document the dose given on the medication administration record as well as any IV site complications/concerns and patient's tolerance of procedure in nurse's notes."

2. On 2/28/19 at 9:00 a.m., Resident W was observed at the nurse's station discussing her

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medications and IV therapy with the nurse.

On 2/28/19 at 9:08 a.m., Resident W indicated she had been in the facility for almost a week post hospitalization for a prior surgery, and was awaiting a second surgery the following week if her infection levels were down. She was not getting her IV antibiotics as ordered. The first night she was admitted to the facility she did not receive her IV antibiotics and that was the reason she was in the facility. The night before, the nurse (she could not remember her name) came into the room to flush her PICC line and couldn't. The resident told the nurse it was hurting her as she attempted to flush the line and there was blood on the bandage. The line would not flush and the fluid came right back out soaking the bandage. The PICC line flushes had started hurting two days ago, but when she reported this to the nurse, she was told it should not hurt it was just saline. When the PICC line did not flush the night before, the nurse told the resident she would have to call the hospital on 2/28/19 herself and report the problems. Since the PICC line was not working properly the resident had missed two more doses of her IV antibiotics from the night before and that morning. The resident had taken the bloody bandage off herself the previous evening that had not been changed since admission.

Record review was completed for Resident W on 2/28/19 at 12:08 p.m. The record indicated the resident was admitted on 2/22/19 with diagnoses to include, but were not limited to, bacterial meningitis, methicillin-resistant staphylococcus aureus (MRSA) infection, non-rheumatic mitral (valve) stenosis, pulmonary embolism with acute cor pumonale (abnormal enlargement of the right side of the heart), viral hepatitis B, acute hepatitis

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	C, and heart failure. Review of Resident W's Physician's orders, indicated the following: - Dated 2/25/19, "Vancomycin HCI in Dextrose Solution [antibiotic used to treat serious bacterial infections] 750-5 mg/150 [milliliters] ml, use 750 mg IV every 12 hours for infection" - Dated 2/27/19, change PICC line dressing weekly, one time a day every Tuesday -Dated 2/28/19, may have PICC replaced due to PICC line becoming dislodged The clinical record lacked orders to flush the PICC line or to monitor the PICC line dressing. Review of Resident W's "Medication Administration Record" for Resident B, dated February 2019, indicated the resident's Vancomycin HCI in Dextrose Solution was not documented as administered on 2/22/19. The Vancomycin was documented as administered on the evening of 2/27/19 and morning of 2/28/19, although the PICC line was not functional. Review of Resident W's care plans, indicated "2/28/19 1. Focus: Potential for infection related to catheter direct access to blood. PICC IV. Goal: [Resident] is able to express discomfort and complications related to IV Therapy. [Resident] will display no adverse effects from IV medications. Interventions: IV medications/flushes per physician order. Monitor for signs or symptoms of air embolism. Report abnormal findings to physician ....When flushing a PICC catheter/midline catheter, use only a 10 ml syringe or larger ..." On 2/28/19 at 1:25 p.m., the DON indicated Resident W had been going out to see the Infectious Disease physician. The facility had not			

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acquired copies of notes from the Infectious Disease physician visits.

3. On 2/28/19 at 9:05 a.m., Resident X was observed ambulating down the hallway with her roommate discussing concerns regarding their IV therapy.

On 2/28/19 at 9: 18 a.m., Resident X indicated she had been in the facility approximately 3 weeks, and was admitted with IV antibiotics and a PICC line. On 2/19/19, the PICC line was discontinued and oral antibiotics ordered by the Infectious Disease physician due to concerns of the PICC line not being cared for properly, not being flushed by orders, and there had not been a cap on the PICC line during the visit. The nurses had told the resident on her 2nd day of admission she could unhook the PICC herself when the infusion was finished. They did not do the flushes of the PICC lines. The PICC line dislodged, she went to the hospital, and had the PICC line removed as it was not functional. The PICC line flushes, soaks, and dressing changes had not been completed per her physician's orders.

Record review was completed for Resident X on 2/28/19 at 1:01 p.m. The record indicated the resident was admitted on 2/13/19. Her diagnoses included, but were not limited to, arthritis related to other bacteria of right shoulder, sepsis (a life-threatening complication of an infection) due to MRSA, anemia, acute hematogenous osteomyelitis (infection of the bone), chronic embolism and thrombosis (blood clots) of unknown vein, acquired absence of right leg below knee, and viral hepatitis C. Review of Resident X's Physician's orders indicated the following:

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-Dated 2/13/19, "Vancomycin HCI solution, use 1 gram IV every 12 hours for MRSA until 3/1/19"
-Dated 2/21/19, "change PICC line dressing every Friday, stop 2/26/19"

The clinical record lacked an order to flush the PICC line.

Review of Resident X's care plans, indicated "...Potential for infection related to catheter direct access to blood. Infection signs and symptoms. PICC IV ..."

On 2/28/19 at 1:25 p.m., the DON indicated Resident X had been going out to see the Infectious Disease physician. The facility had not acquired copies of notes from the Infectious Disease physician visits.

4. On 2/26/19 at 1:58 p.m., Resident J was observed ambulating down the hallway rolling her IV pole with two empty antibiotic IV bags on the pole. The pink label on the IV bags were blank, there were no dates on the bags, no time the antibiotics had been administered, and no nurse's name to indicate who had hung the bags. The PICC line dressing on the left inner arm was dated 2/22/19. The resident indicated the dressing had not been changed since she was admitted from the hospital.

On 2/27/19 at 10:44 a.m., Resident J was observed in her room. The PICC line dressing was dated 2/22/19 and she indicate it still had not been changed since her admission.

Record review was completed for Resident J on 2/28/19 at 9:30 a.m. The record indicated the resident's diagnoses included, but were not limited to, IV antibiotics status post

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hospitalization for acute bacterial endocarditis (heart valve infection) and heroine abuse. Review of Resident J's Physician's orders indicated the following:

-Dated 2/22/19, "Ampicillin-Sulbactam Sodium [treats bacterial infections] reconstituted 3 (2-1) gram. Use 3 gm IV every 6 hours for endocarditis with methicillin-susceptible staphylococcus aureus [MSSA] bacteremia/sepsis pulmonary emboli for 18 days."
-Dated 2/22/19 Cefepime HCI Solution reconstituted gm. Use 1 gm IV every 6 hours for endocarditis with MSSA bacteremia/septic pulmonary emboli for 18 days."

The clinical record lacked orders to flush the PICC line or to monitor the PICC line dressing.

Review of Resident J's "Medication Administration Record", dated February 2019, lacked orders for flushing the PICC line or the changing of the PICC line dressing.

On 2/27/19 at 11:40 a.m., the DON provided a hand written copy of a "Baseline Care Plan" for Resident J dated 2/22/19. The care plan indicated, "...IV Medication: PICC line, right arm, dressing change weekly." and The Physician's orders for Resident J, dated 2/27/19, to change the PICC line dressing one time a day every 7 days for IV therapy.

On 2/28/19 at 1:25 p.m., the DON indicated, she was not aware Resident J was going out to see the Infectious Disease physician. The facility had not acquired copies of notes from the Infectious Disease physician visits.

This Federal tag relates to Complaints IN00284670.

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	3.1-47(a)(2)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record	F 0755	**Corrective actions**	03/27/2019

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	review, the facility failed to maintain a system for the reconciliation of controlled medications on 6 of 6 medication carts (100 Hall medication carts 1, 2, 3, and 200 Hall medication carts 1, 2, 3). This deficient practice resulted in a drug diversion of narcotics for 1 resident. (Resident F) Findings include: On 2/25/19 at 3:30 p.m., the Executive Director (ED) provided a report, titled "Indiana State Department of Health Survey Report System", dated 1/14/19. The report indicated "At approximately 3:00 p.m. on 1/14/19, the Director of Nursing [DON] was notified that a medication card containing 16 hydrocodone for [Resident F] was missing from the medication cart ..." Record review for Resident F was completed on 2/26/19 at 9:50 a.m. The record indicated, the resident was admitted on 1/5/19 with diagnosis to include, but was not limited to, a displaced fracture of left femur. Review of Physician's orders for Resident F indicated the following: -Dated 1/5/19, Norco (narcotic pain reliever of hydrocodone and acetaminophen) 5-325 milligrams (mg), give 1 tablet by mouth every 4 hours as needed for pain -Dated 1/5/19, Acetaminophen 325 mg, give 2 tablets by mouth every 4 hours as needed for mild pain to moderate pain -Dated 1/9/19, Norco 7.5-325 mg, give 1 tablet every 4 hours as needed for pain Review of care plans for Resident F included, but were not limited to, "...Focus: [Resident] is at risk for alteration in comfort related to left femur fracture and general complaint of pain. Goal: [Resident] will not have an interruption in normal		**accomplished for those residents found to be affected by the alleged deficient practice:** All residents have the potential to be affected by this alleged deficient practice **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: The Director of Nursing or designee will conduct a review of the following: conduct a controlled medication reconciliation on each medication cart to ensure there are no discrepancies. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Director of Nursing or designee will in-service the Licensed Nurses and Qualified Medication Aides on the following policies: Medication Controlled Drugs and Security **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The Director of Nursing or designee will audit all medication carts 5 times per week for 2 weeks, then 1 times per week for	

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	activities due to pain. Interventions: Administer medications as ordered. See medication record. Monitor for effectiveness and side effects ..." Review of the 100 hallway "Shift Controlled Substance Inventory Sheets", dated February 2018, with documentation of shift-to-shift nurse signatures to indicate narcotics had been counted. There should have been 152 signatures in each of the 3 binders, the following was observed: -Cart 1: There were 63 of 152 signatures not documented. -Cart 2: There were 61 of 152 signatures not documented. -Cart 3: There were 65 of 152 signatures not documented. Review of the 200 hallway "Shift Controlled Substance Inventory Sheets", dated February 2018, with documentation of shift-to-shift nurse signatures to indicate narcotics had been counted. There should have been 152 signatures in each of the 3 binders, the following was observed: -Cart 1: There was no documentation found in the narcotic binder for 2/1/19 - 2/24/19. There were 5 of 8 signatures not documented on 2/25/19 - 2/26/19. -Cart 2: There was no documentation found in the narcotic binder for 2/1/19 - 2/24/19. There were 6 of 8 signatures not documented on 2/25/19 - 2/26/19. -Cart 3: There was no documentation found in the narcotic binder for 2/1/19 - 2/24/19. There were 7 of 8 signatures not documented on 2/25/19 - 2/26/19.		4 weeks, then monthly for 4 months to ensure compliance: review shift to shift reconciliation of controlled medications to ensure it is in place without discrepancies. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	On 2/26/19 at 10:30 a.m., the "Shift Controlled Substance Inventory Sheets" on 100 hallway had been removed from the narcotic binders on the 3 medication carts. The Director of Nursing (DON) indicated, the narcotic count sheets were to be left on the medication carts, she did not know where they were. The count sheets were found in an office on the 100 hallway. The DON indicated, Qualified Medication Aide (QMA) 8 had removed them from the carts to file. Review of the 100 hallway "Shift Controlled Substance Inventory Sheets", dated January 2018, with documentation of shift-to-shift nurse signatures to indicate narcotics had been counted. There should have been 186 signatures in each of the 3 binders, the following was observed: -Cart 1: There were 79 of the 186 signatures not documented. -Cart 2: There were 82 of the 186 signatures not documented, to include no signatures on the night shift of 1/13/19, or any shift on 1/14/19, when Resident F's narcotics were found to be missing. -Cart 3: There were 84 of the 186 signatures not documented. On 2/26/19 at 1:05 p.m., the DON indicated, on 1/14/19, during morning shift change Licensed Practical Nurse (LPN) 5 who was counting off from the night shift and Registered Nurse (RN) 4 who was signing in for the day shift found a card of hydrocodone 7.5-325 mg missing. Even though there were narcotics unaccounted for RN 4 accepted the cart keys, locked the cart, and went to attend to another resident. When she returned to the cart LPN 5 had clocked out and left the facility. Towards the end of the day shift, RN 4			

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	reported to the DON there was a missing narcotic card. Both nurses were drug tested, and statements were received from both of the staff. LPN 5 tested positive for an unrelated narcotic, and voluntarily left employment. RN 4 was counseled on the narcotic policy, as she delayed in reporting the missing narcotics. The nurse should have reported the missing medications when they were not found and not delayed in reporting throughout the entire shift. On 2/26/19 at 1:15 p.m., RN 4 indicated on 1/14/19 during morning shift change count, Resident F's narcotics were the first one's counted, and there were two separate discrepancies found. There was a card of 16 hydrocodone tablets missing but the count sheet was there, the medication was never found. Then there was another card of hydrocodone for the same resident that was in the cart, but the count sheet was missing, and the count sheet was never found. When the card of pills was found missing, LPN 5 became agitated and was making negative statements. As the nurses were searching for the missing card of medications, a resident approached the cart and requested a pain pill. RN 4 left to deal with the resident. Upon returning to the nurse's station, a fellow day nurse was running late, so RN 4 counted a second medication cart, and when finished found that LPN 5 had left the facility. RN 4 reported the missing card and count sheet to another employee who came in, but did not report to the DON until later in the day. RN 4 wrote her statement, was suspended pending investigation, and when returned to work was counseling by the DON regarding the narcotic policy. On 2/26/19 at 1:28 p.m., RN 4 indicated the narcotic counts were to be completed daily between shifts, both nurses were to sign, and			

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	they were to make sure all the narcotic sheets and medication cards match. She verified there were no nurse signatures on the 100 hallway medication cart 2, on 1/14/19, to indicate narcotic counts were completed for Resident F's medications. She was not sure why the nurses were not signing the count sheets. Sometimes the sheets were full with no blank spaces for signatures. On 2/28/19 at 3:45 p.m., the DON indicated the nurse at shift change and unit managers were responsible for assuring narcotic counts were completed and correct. Nurses should not accept the keys if the counts were not done or the counts were not verified as accurate. They should have been monitoring the nurses to make sure the process was done correctly and the counts were correct. On 2/26/19 at 12:55 p.m., the Executive Director (ED) provided a policy, titled "Medication Controlled Drugs and Security", revised 7/25/18. The policy indicated, "Narcotics, scheduled or controlled drugs are medications that pose a high risk for addiction when improperly taken, and are known to depress the respiratory system which, if taken inappropriately could lead to overdose up to and including death. For this reason narcotics will be kept under double lock and will be counted by on-coming and off-going nurse at the end of each shift and before keys are passed to next shift ...d. Drug diversion will be treated as misappropriation of Resident Property and the Board of Nursing will be notified as appropriate for known drug diversions or suspected drug diversion after careful review and evidence collection ...Narcotic keys will be transferred after a narcotic count is completed and verified current whether the transfer of key occurs end of shift or			

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	155664	A. BUILDING 00 B. WING	02/28/2019

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	during a shift ...Controlled drugs as well as the controlled drug count sheets and cards, are counted every shift change by the nurse reporting on duty with the nurse reporting off duty ...The inventory of the controlled drugs, count sheets and number of cards must be recorded on the narcotic records and signed for correctness of count ...The controlled drug record must be signed by the nurse coming on duty and the going off duty to verify that the count of all controlled drugs is correct after count has been completed ...In the event a discrepancy is found, check the resident's medication sheets and chart to see if a narcotic has been administered and not recorded ...If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the supervisor for immediate investigation. Nurses, or qualified medication aide may not leave the unit until directed to do so by the immediate supervisor ..." 3.1-25(e)(3)			
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and review, the facility failed to maintain a clean and sanitary environment. This practice had the potential to effect 80 of 80 residents on the 100 and 200 hallways. Findings include: On 2/25/19 at 2:40 p.m., during an afternoon tour of the 100 hallway, the following was observed:	F 0921	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Residents affected rooms / areas were cleaned with all linen, clothes and debris removed from floor. **Identification of other residents having the potential to be**	03/27/2019

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	a. Room 112 had a strong foul odor permeating out into the hallway. There were soiled clothing and trash on the floor. b. Room 115 had a pile of soiled clothing in the corner of the room. c. On 2/25/19 at 2:50 p.m., during a tour of the main dining room there were soiled table clothes under a table at the entrance of the dining room, multiple used clothing protectors on a chair and on top of a table, and soiled cups and glasses remained on the multiple tables. Food debris was observed on the floor throughout the dining room. On 2/25/19 at 3:22 p.m., during an afternoon tour of the 200 hallway, the following was observed: d. Room 219 was observed with unidentified dark debris around the bed, and linens on the floor under the bed. e. Straw wrappers on the floor outside room 226, a housekeeper was observed walking past the debris 3 times and did not pick it up. f. Room 227 had a clear bag open on the bed with soiled linens and trash mixed. g. Room 229 had an open red isolation bag lying on the floor inside the doorway, an open box of gloves on top the isolation cart next to the red bag, and gloves hanging out of a glove container on the wall above the isolation bag. h. A visitor from room 231 carried a clear bag of trash out of the resident room, to include trash and fast food take-out containers, and placed it on the floor in the hallway outside of a secured utility door. Staff nearby acknowledged the visitor, but		**affected by the same alleged deficient practice and Corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. Executive Director or designee will round the facility to ensure a clean and sanitary environment is maintained **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Executive Director or designee will conduct the following in-service: 1.Staff educated on maintaining a clean and sanitary environment, including not placing linens or clothes on the floor, picking up debris, cleaning any spills are soiled areas. 2. Housekeeping to follow the daily cleaning schedule. Policy on daily patient room cleaning reviewed **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The Executive Director or designee will complete an audit 5 times per week for 2 weeks, then 1 times per week for 4 weeks, then monthly for 4 months to ensure compliance: walking rounds to ensure a clean and sanitary environment is	

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	the trash remained on the floor in excess of 20 minutes as residents and visitors passed by. i. On 2/26/19 at 9:13 a.m., during a tour of the 200 hallway Room 233 had a soiled brief lying open on the floor at the end of the bed, visible to the hallway. j. On 2/28/19 at 8:50 a.m., three residents were observed smoking within 6 feet of front entrance door. On 2/28/19 at 8:55 a.m., during a morning tour of the 100 hallway, the following was observed: k. Room 101 had paper debris on floor around the bed near the hallway, 2 clear trash bags beside the bed, and 1 bag of trash on the chair. There were 2 soiled wash clothes in clear bags near the door on the floor. l. Room 129 had a soiled wash cloth on floor near the doorway. m. Room 113 had a large pile of dried mud in the center of the room, nearest the bed by the windows, and scattered throughout the room. The resident indicated, her son had tracked in the dirt the evening before on his boots, he had scooped the mud into a pile as best he could, and had asked staff for a broom so he could sweep it up. The resident indicated, she was embarrassed for others to see the mess as she wasn't a dirty person. She indicated, 4 staff members had been in the room since her son left at 8:00 p.m. the evening before, they did not bring a broom, and told her they would contact housekeeping to clean it up. n. Room 215 had a gown under the bed, paper		maintained. . The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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debris on floor, a dark sticky substance on floor at the end of bed and tracked between the beds.

o. Room 207 had 2 bags of soiled linens on the floor, and paper debris around the room and under the bed.

On 2/28/19 at 3:08 p.m., the Executive Director (ED) and Director of Nursing (DON) indicated every room was to be cleaned daily and there was a deep clean schedule for each room monthly. Nursing staff were to put soiled linens in a clear bag and those bags were to go to the soiled linen container in the utility room. Trash was to be in a clear bag and it went into the trash container in the soiled utility room. Linens and trash were never to be placed on the floor. If a resident was in isolation the same cleaning schedule was maintained. Isolation trash would go into the regular trash bag in the room. There were no red bags used in resident rooms. The isolation trash would be removed from the resident room by being tied and put into the soiled utility barrel by nursing staff. If isolation was for a wound, the trash would go into the red biohazard trash in the soiled utility room. The biohazard box was kept in the soiled utility room. A resident could let any staff member know if they wanted to request to have their room cleaned. It would be addressed by the person asked or by contacting housekeeping to clean as soon as possible. The housekeeping supervisor was responsible for making sure resident rooms were cleaned by the schedule and the ED would also monitor the rooms.

On 2/28/19 at 4:00 p.m., the ED provided a document, title "Daily Patient Room Cleaning", dated 6/2016. The document indicated resident rooms were to have the trash emptied, all horizontal surfaces were to be dusted, spot

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	cleaning of all vertical surfaces, dust mop floor to gather all trash and debris from the floor, and damp mop the floor with germicide solution from the back corner to the door daily. This Federal tag relates to Complaints IN00284670, and IN00288413. 3.1-19(f)(5) 3.1-19(g)(1)			