

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2019
--	---	--	---

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

(X4) ID PREFIX TAG	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 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00301266 and IN00301867.</p> <p>Complaint IN00301266 - Substantiated. Federal deficiencies related to the allegations are cited at F686.</p> <p>Complaint IN00301867 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: July 24, 25, and 26, 2019</p> <p>Facility number: 010666 Provider number: 155664 AIM number: 200229930</p> <p>Census Bed Type: SNF/NF: 85 Total: 85</p> <p>Census Payor Type: Medicare: 11 Medicaid: 65 Other: 9 Total: 85</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed on August 2, 2019.</p>	F 0000	<i>The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Eagle Creek Healthcare Center.</i>	
F 0686 SS=G Bldg. 00	<p>483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of</p>			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EAGLE CREEK HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident at risk for pressure ulcers did not develop pressure ulcers resulting in osteomyelitis (infection of the bone) for 1 of 3 residents reviewed for pressure ulcers (Resident D).</p> <p>Findings include:</p> <p>During an observation of Resident D on 7/25/19 at 10:40 a.m., the resident was lying on his back in bed with his eyes closed, head of bed elevated, cushion under his knees, and a blue cushion elbow bootie on his right elbow.</p> <p>During an observation of Resident D on 7/25/19 at 11:21 a.m., the resident was lying on his back in bed with his eyes closed, head of bed elevated, cushion under his knees, and a blue cushion elbow bootie on his right elbow.</p> <p>During an observation of Resident D on 7/25/19 at 4:10 p.m., the resident was lying on his back in bed with his eyes open, head of bed elevated, cushion under knees, and a blue cushion elbow bootie on his right elbow.</p> <p>During an observation of Resident D on 7/26/19 at</p>	F 0686	<p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>Resident D continues to have all interventions in place, including turning and repositioning, and elevated upper extremity. Resident D's Braden Scale assessment was updated to reflect an accurate level of risk.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken</p> <p>All other residents residing in the facility have the potential to be affected. An audit was conducted on residents to identify any skin areas. All residents have had a new Braden Scale assessment completed.</p>	08/22/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2019
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>12:26 p.m., the resident was lying on his back in bed with his eyes closed, head of bed elevated, cushion under knees, and a blue cushion elbow bootie on his right elbow.</p> <p>During an observation of Resident D on 7/26/19 at 1:22 p.m., the resident was lying in bed on his back with his eyes closed, head of bed elevated, cushion under knees, and a blue cushion/bootie on right elbow without a hole in the elbow bootie to keep pressure off of the elbow wound. The Regional Director of Clinical Operations indicated a new elbow bootie had been placed on the resident this date to allow for washing of the previous boot with the hole in the elbow. Maintenance personnel were helping to cut holes in new elbow booties to meet the resident's needs.</p> <p>During an observation of Resident D on 7/26/19 at 2:45 p.m., the resident was lying in bed on his back with his eyes closed, head of the bed elevated, cushion under knees, and a blue cushion elbow bootie on both elbows. There was no pillow beside the resident being used as a positioning prop, or to prop the arms off of the mattress.</p> <p>A record review was completed for Resident D on 7/25/19 at 1:38 p.m. The record indicated the resident was admitted to the facility on 4/3/19 with diagnoses to include, but were not limited to: trach (tracheostomy) status (provides an air passage to help with breathing when the usual route for breathing is obstructed or impaired), anoxic brain damage (lack of oxygen causing cells in brain tissue to die), chronic pain, and seizures.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 5/25/19, indicated Resident D's cognitive status was unable to be assessed. He</p>		<p>3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>All nursing staff to be inserviced on Skin Care and Wound Management policy with emphasis on preventative measures and interventions by DON/designee.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>The DON/Designee will audit 5 residents requiring pressure ulcer interventions 5 times per week for 2 weeks, 5 residents weekly for 4 weeks and 5 residents monthly for 3 months. The Director of Nursing or Designee will report to the QAPI committee findings and the QA committee will determine when compliance is achieved or if ongoing monitoring is required.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EAGLE CREEK HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>was a total dependence of 2 or more persons for bed mobility, dressing, toilet use, personal hygiene, and the bathing process. He was a limited assist of 1 person for transfers. The resident was always incontinent of bladder and bowel.</p> <p>A review of Resident D's Care Plans, to include, but not limited to, "1. 4/30/19 Focus: Actual alteration in skin integrity (pressure ulcer). Decreased Mobility, Urinary Incontinence. Pressure ulcer to right elbow and posterior neck. Goal: Pressure ulcer will be free of slough or necrotic tissue. [Resident D's] pressure ulcer will respond to treatment modalities as evidence by reduction in wound measurements. Wound will be free of infection. Wound will be covered with epithelial tissue or resurfaced with new skin even with possible discoloration. Interventions: Administer medications per physician order. See medication record. Follow physician orders for skin care and treatments. Monitor for signs and symptoms of infection and report to physician for care and treatment or debride. Protective skin care with incontinent care...." The care plan did not indicate a turn and repositioning program, or off-loading of the elbow.</p> <p>A physician order, dated 3/8/19, indicated Eucerin Cream (skin protectant), apply to dry and cracking skin topically two times a day for dry and cracking skin.</p> <p>A physician order, dated 3/8/19, indicated Calmoseptine Ointment 0.44-20.6 % (Menthol-Zinc Oxide, moisture barrier) apply to pressure ulcer topically every shift for pressure ulcer.</p> <p>A physician order, dated 4/3/19, indicated may have pressure relieving/reducing device on bed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EAGLE CREEK HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>A physician order, dated 4/3/19, indicated consult Wound MD as indicated.</p> <p>On a progress note, dated 4/17/2019 at 1:09 p.m., Licensed Practical Nurse (LPN) 8 indicated there were new skin issues to the neck where the collar held the trach, and an area to the right elbow. There was scant bleeding to both areas and they were free from odor.</p> <p>Review of a wound reports for Resident D, titled, "Healogics," dated 4/29/19. The reports indicated pressure ulcers to the right elbow and posterior neck due to pressure. The right elbow wound was classified as an unstageable (Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed) wound. The elbow wound measured 1.1 centimeters (cm) length x (by) 0.7 cm width x 0.1 cm depth, and there was a fat layer (subcutaneous tissue) exposed. "Santyl to elbow to enzymatically debride necrotic tissue; avoid sustained contact between elbow and mattress, rails, etc. as this may act as a further source of pressure."</p> <p>A wound report for Resident D, titled, "Healogics," dated 5/6/19, indicated pressure ulcer to the right elbow due to pressure. The right elbow wound was classified as an unstageable wound. The elbow wound measured 1.2 cm length x 0.5 cm width x 0.1 cm depth, and there was a fat layer exposed. The wound progress was worsening.</p> <p>A wound report for Resident D, titled, "Healogics," dated 5/20/19, indicated pressure ulcer to the right elbow due to pressure. The right</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2019
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>elbow wound was classified as an unstageable wound. The elbow wound measured 1.2 cm length x 0.6 cm width x 0.1 cm depth, and there was a fat layer exposed.</p> <p>A wound report for Resident D, titled, "Healogics," dated 6/3/19, indicated pressure ulcer to the right elbow due to pressure. The right elbow wound was classified as an unstageable wound. The elbow wound measured 1.0 cm length x 0.7 cm width x 0.3 cm depth, and there was fat layer exposed. The wound progress was worsening.</p> <p>A wound report for Resident D, titled, "Healogics," dated 6/24/19, indicated pressure ulcer to the right elbow due to pressure. The right elbow wound was classified as a Stage IV (extensive loss or damage to tissue, muscle and bones, and often feature muscle and bone that is exposed) wound. The elbow wound measured 1.2 cm length x 0.7 cm width x 0.3 cm depth, and there was bone, muscle, and a fat layer exposed. The wound progress was worsening. The report indicated, "area enlarged with increased drainage and bone exposed; presumptive diagnosis of osteomyelitis can be made. Will confirm with serum acute phase reactants and imaging; will need removal of exposed bone for culture, as well as to allow for healing to progress."</p> <p>On a progress note, dated 7/1/19 at 11:20 a.m., Registered Nurse (RN) 9 indicated, the resident was seen by the wound doctor and he had requested a magnetic resonance imaging (MRI) scan of the right elbow.</p> <p>An MRI for Resident D, dated 7/5/19, indicated the right elbow wound was a Stage IV pressure wound for 2 months. The impression indicated,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EAGLE CREEK HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>findings were consistent with early osteomyelitis of the olecranon (elbow) with an adjacent skin ulcer.</p> <p>A wound report for Resident D, titled, "Healogics", dated 7/15/19, indicated pressure ulcer to the right elbow due to pressure. The right elbow wound was classified as an unstageable wound. The elbow wound measured 2.0 cm length x 1.3 cm width x 0.5 cm depth, and there was bone, muscle, and a fat layer exposed. The wound progression was worsening.</p> <p>A physician order, dated 7/15/19, indicated to cleanse wound bed on the right elbow with NS (normal saline) or wound cleanser, pat dry, and apply barrier cream to periwound (tissue surrounding the wound). Then apply santyl (debriding agent) to wound bed, followed by alginat (dressing used on wounds that have a large amount of exudate). Then fill the remainder of wound bed with fluffed gauze to address the dead space. Finally, cover with gauze and secure daily and PRN (as needed) when soiled. Treatment was to be done one time a day for wound care and as needed for soilage or displacement.</p> <p>A physician order, dated 7/22/19, indicated use Meropenem (broad spectrum antibiotic) Solution Reconstituted 1 GM (gram), 1 gram intravenously every 8 hours for osteomyelitis until 09/02/2019.</p> <p>On a progress note, dated 7/22/2019 at 11:51 a.m., LPN 10 indicated the resident was seen by the wound doctor who reviewed the results of the MRI. The MRI report indicated the findings were consistent with early osteomyelitis. New orders were received to place a peripherally inserted central catheter (PICC) line and start IV</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2019
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Meropenem for 42 days.</p> <p>During an interview with RN 11 on 7/25/29 at 4:15 p.m., the nurse indicated, Resident D had a wound on his elbow, she was not sure how he got it, and treatments were done every-other-day.</p> <p>During an interview with LPN 10 on 7/25/19 at 4:30 p.m., the wound nurse indicated, Resident D had a Stage IV pressure ulcer on the right elbow, and a recent MRI had been completed with a diagnosis of osteomyelitis. The wound doctor had ordered Meropenem IV, and if the wound improved, the plan was to place a wound vacuum to help healing. LPN 10 indicated, she thought the wound was unavoidable due to the resident's vegetative state. Resident D was on a turn and reposition every 2 hour schedule, he had an elbow boot, numerous treatments, and still had not improved. She was not sure how the resident acquired the area as he had the elbow boot and was turned. The elbows were originally elevated with pillows but the pillows would shift, so after the open area was noted bunny elbow boots were initiated.</p> <p>During an interview with the Director of Nursing (DON) on 7/26/19 at 2:38 p.m., she indicated, the resident was completely dependent with all care. He was on tube feedings so the Registered Dietician (RD) reviewed him for adequate nutrition for healing. Treatments were in place and had been followed by wound care. The elbow wound had been acquired in-house, but even though there were established treatments and interventions in place, the area still deteriorated. The DON had not been in the room to see the Resident D turned, but there was a pillow beside him that was probably used to prop him when he was turned.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2019
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>During an interview on 7/26/19 at 2:49 p.m., LPN 7 indicated, Resident D already had the right elbow wound when she was hired, so she was not sure how he had acquired the wound. The elbow treatment was completed by the nurse daily per the wound doctor orders, and staff working with her would shift the resident off his bottom and prop with a pillow to relieve pressure. The resident had dark blue elbow protectors until today and he now has thicker light blue elbow cushions.</p> <p>On 7/26/19 at 12:15 p.m., Regional Director of Clinical Operations provided a policy, titled, "Skin Care & Wound Management Overview", dated 7/1/2016. The policy indicated, "The facility staff strives to prevent resident/patient skin impairment and to promote the healing of existing wounds. The interdisciplinary team works with the resident/patient and/or family/responsible party to identify and implement interventions to prevent and treat potential skin integrity issues ...Identify diagnosis or conditions to place the resident/patient at risk for pressure ulcer development ...Develop a care plan with individualized interventions to address risk factors ...Evaluate for consistent implementation of interventions and effectiveness at clinical meetings. Modify and document goals and intervention as indicated ..."</p> <p>This Federal tag relates to Complaint IN00301266.</p> <p>3.1-40(a)(2)</p>			