| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00341693. This visit included a COVID-19 Focused Infection Control Survey.<br><br>Complaint IN00341693- Substantiated. Federal deficiencies are cited at F610 and F684.<br><br>Survey dates: November 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: 85<br>Total: 85<br><br>Census Payor Type:<br>Medicare: 9<br>Medicaid: 63<br>Other: 13<br>Total: 85<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on November 30, 2020. | F 0000 | | |
| F 0610<br>SS=D<br>Bldg. 00 | 483.12(c)(2)-(4)<br>Investigate/Prevent/Correct Alleged Violation<br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged | | | |

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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>Based on observation, interview, and record review, the facility failed to report neglect on two separate occasions after the resident, (Resident C), staff, and Emergency Medical Staff (EMS) complained about the development of maggots under a resident's abdominal pannus (an area of excess skin and fat that hangs over the pubic region, often described as an apron of lower abdominal skin and fat), for 1 of 3 residents reviewed for neglect(Resident C).<br><br>Findings include:<br><br>On 11/19/20 at 10:33 a.m., Resident C was observed lying on her stomach, propped up on her elbows in a bariatric bed. She was observed to be morbidly obese, and an abdominal pannus was displaced outward on her right side, partially covered by the blanket. A Chux pad (a disposable liner used to absorb bodily excretions) was observed placed underneath the pannus. The resident indicated she was miserable and had had the worst experience of her life. She was "so embarrassed" and was still "horrified" by what happened. There was an incident in October | F 0610 | **F 610**<br><br>**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident C - An investigation for the allegation of mistreatment was investigated and reported to the ISDH by the Executive Director.<br><br>**Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by the same alleged deficient practice.<br><br>**Measures put in place and systemic changes made to ensure the alleged deficient** | 12/16/2020 |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | where the staff had not changed her Chux pad in over a week. When she was sent out to the hospital there were maggots under her "tumor." This happened twice. The second time facility staff called EMS (Emergency Medical Staff) to come help move her into a new bed, there were maggots under her "tumor" again.<br><br>During an anonymous interview, during the survey dates of 11/18/20 to 11/19/20, the interviewee indicated Resident C had "a lot" of concerns, but most of her concerns were valid because she was not getting the care she required. The resident was depressed and cried "a lot." When Resident C complained about maggots, she was right. The resident had been on the COVID unit and was in a narrow bed which did not fit her. She could not be cleaned appropriately. On 10/12/20 maggots were present under the resident's pannus, and there was concern the area may have been infected. Resident C was sent to the hospital and it was reported to the Director of Nursing (DON). On 10/27/20 maggots were found a second time. When Resident C was being moved into a new bed she almost fell off and was too scared to move anymore so 911 was called. The EMS crew that assisted Resident C into the new bed witnessed the maggots and reported their concerns to the ED. Staff called EMS because the resident was hanging onto the bed with both hands and was scared to fall.<br><br>During an anonymous interview, during the survey dates of 11/18/20 to 11/19/20, the interviewee indicated, Resident C was not feeling well on 10/27/20 and had to be redirected several times to get cleaned up. Resident C stated she did not want to be moved because she was afraid, she would fall again. The only way to | | **practice does not recur:** Regional Director of Clinical Operations (RDCO) will re-educate the facility staff including the Executive Director and Director of Nursing on the following facility policy, “Indiana Abuse, Neglect, and Misappropriation”, and the guidelines for incident reporting. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 3 residents and 3 staff members will be conducted by the RDCO or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Interview of residents and staff regarding any allegations of abuse / neglect / mistreatment.<br><br>For any allegations identified, ED or designee will ensure the following occurs: Identification: appropriate MD/family notification, completion of accident / incident report, notification to the State Department of Health. Protection: suspension of suspected employee(s) pending outcome of investigation. Investigation: initiate and complete.<br><br>The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | move her was to call for help, so the "nurse called 911." Resident C was hanging on, the staff called for help so she wouldn't fall. When the paramedics got there, there were 3 guys who had to hold her up and approximately 12 to 15 maggots were found. They were crawling around under her abdominal pannus.<br><br>During an interview, on 11/19/20 at 2:56 p.m., the ED indicated Resident C refused care and called 911 and let the EMS come clean her up; she did not refuse care from them. The ED indicated the EMS told her the room was "gross," and the resident was "dirty." There had been an incident where the resident fell, and it scared her, so she started refusing care because she was afraid.<br><br>During an interview, on 11/19/20 at 3:51 p.m., the DON indicated Resident C refused care. She did not know how often the resident refused care, or what care she refused. There were no open areas under Resident C's abdominal pannus, so when she went to the hospital it was not because of wounds. She could not remember exactly why she went to the hospital. The EMS had concerns about the resident's condition, but she did not know what exactly. The ED had reported the concerns to the state. She was unsure what kind of bed Resident C was in when she fell out of her bed.<br><br>On 11/19/20 at 4:07 p.m., during an interview, the DON did not provide any additional information related to the inquiries of Resident C's care, only that, a nurse told her Resident C was headed to the hospital because of maggots. The DON indicated, when allegations of abuse or neglect were reported, she should immediately report to the ED and open an investigation. | | 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 | 11/19/2020 |

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

The hospital summary, dated 10/12/2020, indicated, "...chief complaint: wound infection with maggots... [patient is] bedbound presented to the ED with suspicion for wound infection after nursing at the ECF (extended care facility) found maggots in her panniculitis wound... Patient with allegations of neglect at the ECF ....She was very tearful and at one point stated that she would harm herself if she were to go back to the facility...Assessment and Plan: Problem 1: Sepsis 2/2 panniculitis... Patient reports that they found maggots at the ECF. Erythema (redness of the skin) warmth and purulent drainage (thick with a yellow, green or brown color, with a pungent, strong, foul, fecal or musty odor)... abx (antibiotic) coverage broadly start Vanc/ceftriaxone (a combination antibiotic used to treat bacterial infections) and flagyl for wound care... Problem 7: Alleged neglect... Patient with allegations of neglect at the ECF reporting that they do not change her wound dressing...."

During an interview, on 11/20/20 at 1:46 p.m., the EMS Shift Supervisor indicated, he was called as back up to the facility on 10/27/20 to assist with Resident C's care and transfer to a bariatric bed. He was told by the crew, upon their arrival the room was so filthy that Resident C was inaccessible, so they cleaned and mopped the room. It appeared that housekeeping had been totally absent. Resident C was lying on her stomach in a standard size bed, which was much too small for her. EMS Shift Supervisor indicated he had been on several previous runs for this resident and had reported to staff that Resident C needed to be in a bariatric bed. As the crew lifted Resident C to her knees, where she could help support herself, the nursing staff and EMS staff cleaned her up. The pad she had been

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | laying on was grossly soiled with brown and green drainage, her sheets were also littered with debris, and there were maggots crawling on her, and [nursing] staff indicated there had been maggots on a previous occasion. The EMS Shift Supervisor reported his concerns to the facility administrator.<br><br>State Incident Reports for Resident C were reviewed. There was no incident report for the neglect allegations after maggots were found on Resident C on 10/12/20.<br><br>A State Incident Report, numbered "321", dated 10/27/20, indicated, "... [Resident C] called 911 herself... has an extensive history of refusing care. Fire Department stated care concerns related to the condition of [Resident C's] room. [Resident C] refuses housekeeping and refuses clinical care...." The report lacked documentation of the Resident C's complaint of alleged neglect, or that maggots were witnessed by the nursing staff and EMS.<br><br>A State Incident Report, numbered "322", dated 10/27/20, indicated: "... [Resident C] called emergency services herself... [Resident C] alleged to Emergency Department that facility was not providing care to her. Emergency Department called this writer to express [Resident C's] concerns. [Resident C] has extensive history of refusals. [Resident C] has been educated on importance of allowing care for her well-being...." The report did not indicate the Resident's complaint of alleged neglect, or that maggots were witnessed by the nursing and EMS staff.<br><br>On 11/19/20 at 3:20 p.m., during an interview, the ED indicated EMS had informed her 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | concerns that the resident's room was dirty, and EMS did not like the resident's bed. The ED indicated all allegations of neglect should immediately be reported to her, and an immediately investigated. No concerns were reported to the ED from the DON. The DON should have reported allegations immediately and they should have been immediately investigated. The ED indicated, on 10/27/20 she completed an investigation related to the EMS concerns.<br><br>A policy titled, "[state name] Abuse and Neglect and Misappropriation of Property", dated revised on 5/14/20, was provided by the executive director (ED) on 11/19/20 at 3:39 p.m. The ED indicated this was the current policy being used by the facility at this time. The policy indicated, "...It is irrelevant where the allegations were unfounded- all alleged violation must be reported immediately. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness ... failure to provide personal hygiene resulting in embarrassment, depression, poor self-esteem, self-isolation or physical ... In the event a situation is identified as abuse, neglect, or misappropriation, an investigation by the executive leadership will immediately follow up ...A physical examination (head-to-toe) will be performed by the Director of nursing or designee nurse and documented in the resident's chart ...Documentation of the facts and findings will be completed in each resident medical record ...notify the physicians of each resident, notify the resident representative, update care plans ...Neglect or misappropriation investigation report will be initiated by the Director of Nursing or designee. Initial findings will be reported to the Executive Director, the physician (except in case of misappropriation of funds/ | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | property), and the resident representative ...All alleged violations involving abuse, neglect, exploitation or mistreatment ...are reported immediately, but not later than 2 hours after the allegation is made ...reporting to the administrator (Executive Director) and to other reporting regulatory bodies must occur within twenty-four (24) hours. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are report immediately to the Executive Director/ designee of the facility. State reportable occurrences that directly threatens welfare, safety, or health of a resident...."<br><br>A policy titled, "Abuse and Neglect and Misappropriation of Property", dated revised on 5/14/20, was provided by the executive director (ED) on 11/19/20 at 3:39 p.m. The ED indicated this was the current policy being used by the facility at this time. The policy indicated, "Infestation is defined ...as a spread or swarm in or over in a troublesome manner; infestation is more than a few insects confined to a single area. CMS defines immediate as, 'as soon as possible, but no more than twenty-four (24) hours after the alleged incident is discovered. It is irrelevant where the allegations were unfounded- all alleged violation must be reported immediately. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness ...failure to provide personal hygiene resulting in embarrassment, depression, poor self-esteem, self-isolation or physical harm ...an action or lack of action that places one or more residents in a life-threatening situation, such as ...staff failing to identify, assess, monitor, or respond to | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | residents suffering an acute condition ...In the event a situation is identified as abuse, neglect, or misappropriation, an investigation by the executive leadership will immediately follow up ...A physical examination (head-to-toe) will be performed by the Director of nursing or designee nurse and documented in the resident's chart ...Documentation of the facts and findings will be completed in each resident medical record ...notify the physicians of each resident, notify the resident representative, update care plans ...Neglect or misappropriation investigation report will be initiated by the Director of Nursing or designee. Initial findings will be reported to the Executive Director, the physician (except in case of misappropriation of funds/ property), and the resident representative ...All alleged violations involving abuse, neglect, exploitation or mistreatment ...are reported immediately, but not later than 2 hours after the allegation is made ...reporting to the administrator (Executive Director) and to other reporting regulatory bodies must occur within twenty-four (24) hours. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are report immediately to the Executive Director/ designee of the facility. State reportable occurrences that directly threatens welfare, safety, or health of a resident: ix. Rodent and/ or insect infestation."<br><br>This Federal tag relates to Complaint IN00341693.<br><br>3.1-28(c)<br>3.1-28(d)<br>3.1-28(e) | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| F 0684<br>SS=G<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on observation, interview, and record review, the facility failed to ensure proper personal hygiene for a resident to prevent the development of a maggot infestation underneath her abdominal pannus (an area of excess skin and fat that hangs over the pubic region, often described as an apron of lower abdominal skin and fat), which resulted in actual harm through mental anguish, loss of dignity, and self-worth (Resident C), to complete wound assessments, provide wound care as ordered by their physician, and prevent infection of an intravenous site (IV) resulting in harm when the resident was admitted to the hospital with sepsis (Resident B), and ensure wound dressings were changed, and wounds were assessed as ordered by their physician, for a resident identified as at risk for wound development, with a recent history of wide spread infection (Resident D) for 3 of 3 residents reviewed for quality of care .<br><br>Findings include:<br><br>1. On 11/19/20 at 10:33 a.m., Resident C was observed lying on her stomach, propped up on her elbows in a bariatric bed. She was observed to be morbidly obese, and an abdominal pannus was displaced outward on her right side, partially | F 0684 | **F 684**<br><br>**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:**<br><br>Resident C has had the appropriate hygiene completed and is being followed by social service to ensure her psychosocial well-being is maintained.<br><br>Resident B no longer resides in the facility.<br><br>Resident D has had their wounds assessed by the physician and wound care team, treatments are being completed as ordered.<br><br>**Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: | 12/16/2020 |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | covered by the blanket. A Chux pad (a disposable liner used to absorb bodily excretions) was observed placed underneath the pannus. The resident showed signs of distress as she cried and called out for help. She indicated she had been waiting a long time for her call light to be answered. During the interview the resident indicated she was miserable and had had the worst experience of her life. She was "so embarrassed" and was still "horrified" by what happened. There was an incident in October where the staff had not changed her Chux pad in over a week. When she was sent out to the hospital there were maggots under her "tumor." This happened twice. The second time facility staff called EMS (Emergency Medical Staff) to come help move her into a new bed, there were maggots under her "tumor" again. Resident C was observed crying. She indicated she wanted to go to another facility so she could be kept clean and safe. "Some days I don't feel good, and when I had COVID I didn't want to move at all. No one wants to get maggots!"<br><br>During an interview on 11/19/20 at 12:00 p.m., Resident C indicated she was no longer concerned about the wound under her "tumor" (pannus) because she had been put on wound rounds, and the Wound Doctor, and Wound Nurse were taking care of it. Her biggest concern was that she was so upset because of the maggots, and that they had been found twice. Every time she thought about them, she would "just break down" and could "still see them wiggling around" and it "grossed" her out. No one came to talk with her about what happened directly after, and no one had followed up since.<br><br>During an anonymous interview, during the survey dates of 11/18/20 to 11/19/20, the | | All residents have the potential to be affected by the same alleged deficient practice.<br><br>An audit has been completed on all residents to ensure their skin has been assessed, any resident identified with wounds has had their wound(s) assessed, order obtained for treatment, documentation in the medical record, and a plan of care has been developed.<br><br>An audit has been completed on all residents that have an IV; an assessment of the site, dressing change, and documentation has been completed.<br><br>**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:**<br><br>The DON/designee has educated the nursing staff on the facility policy, “Routine Care _ Bathing Hygiene” with emphasis on ADL care and resident care that promotes psycho social well-being.<br><br>The DON/designee has educated the licensed nursing staff on the facility policy, “Skin Care and Wound Management Overview”, with emphasis on wound | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | interviewee indicated Resident C had "a lot" of concerns, but most of her concerns were valid because she was not getting the care she required. The resident was depressed and cried "a lot." When Resident C complained about maggots, she was right. The resident had been on the COVID unit and was in a narrow bed which did not fit her. She could not be cleaned appropriately. On 10/12/20 maggots were present under the resident's pannus, and there was concern the area may have been infected. Resident C was sent to the hospital and it was reported to the Director of Nursing (DON). On 10/27/20 maggots were found a second time. When Resident C was being moved into a new bed she almost fell off and was too scared to move anymore so 911 was called. The EMS crew that assisted Resident C into the new bed witnessed the maggots and reported their concerns to the ED. Staff called EMS because the resident was hanging onto the bed with both hands and was scared to fall.<br><br>During an interview, on 11/19/20 at 2:56 p.m., the ED indicated Resident C refused care and called 911 and let the EMS come clean her up; she did not refuse care from them. The ED indicated the EMS told her the room was "gross," and the resident was "dirty." There had been an incident where the resident fell, and it scared her, so she started refusing care because she was afraid. The staff gave the resident a journal to journal her feelings and tried to encourage her more.<br><br>During an anonymous interview, during the survey dates of 11/18/20 to 11/19/20, the interviewee indicated, Resident C was not feeling well on 10/27/20 and had to be redirected several times to get cleaned up. Resident C | | assessment, treatment orders, and documentation.<br><br>The DON/designee has educated the licensed nursing staff on the facility policy, “Physician Orders”.<br><br>The DON/designee has educated the licensed nursing staff on IV maintenance, with emphasis on assessment of the site, dressing changes, and documentation.<br><br>**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:**<br><br>The DON/designee will observe/interview 5 residents weekly for 4 weeks, then 10 residents monthly for 5 months to ensure appropriate ADL and hygiene care has been provided.<br><br>The DON/wound nurse will audit/observe 5 residents weekly for 4 weeks, then 3 residents weekly for 4 weeks, then 10 residents monthly for treatment changes, including the assessment, order accuracy, and documentation.<br><br>The DON/designee will audit/observe 5 residents weekly for 4 weeks, then 3 residents weekly for 4 weeks, then 10 residents monthly for 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | stated she did not want to be moved because she was afraid, she would fall again. The only way to move her was to call for help, so the "nurse called 911." Resident C was hanging on, the staff called for help so she wouldn't fall. When the paramedics got there, there were 3 guys who had to hold her up and approximately 12 to 15 maggots were found. They were crawling around under her abdominal pannus.<br><br>During an interview, on 11/19/20 at 3:51 p.m., the DON indicated Resident C refused care. She did not know how often the resident refused care, or what care she refused. There were no open areas under Resident C's abdominal pannus, so when she went to the hospital it was not because of wounds. She could not remember exactly why she went to the hospital. The EMS had concerns about the resident's condition, but she did not know what exactly. She was unsure what kind of bed Resident C was in when she fell out of her bed.<br><br>On 11/19/20 at 4:15 p.m., during an interview, the ED indicated, "in a perfect world" staff should re-direct a resident who refused care at least three times each shift and document each time they refused. Staff should care plan what and why a resident refused care and update the care plan with new/additional approaches to try. Staff should contact the resident's doctor to address the refusals. If the resident was refusing care a point that their health was in danger, staff should have made a mental health referral, or send the resident to the hospital for care we are not able to do here.<br><br>On 11/18/20 at 10:00 a.m., Resident C's medical record was reviewed. The resident's diagnoses included but were not limited to lymphedema, | | accuracy and completion.<br><br>The DON/designee will audit/observe 5 residents weekly for 4 weeks, then 3 residents weekly for 4 weeks, then 10 residents monthly to ensure IV sites are assessed appropriately, and dressing changes completed as ordered.<br><br>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. | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | morbid obesity, COVID-19, major depressive disorder.<br><br>The current physician orders, on11/18/20, included but were not limited to, "Cleanse folds everyday with warm soapy water and dry well. Apply nystatin powder [an anti-fungal medication] to folds PRN (as needed) and for soilage ...Cleanse right lower abdominal wound with sterile water, pat dry. Skin prep to periwound ...Calcium AG [Alginate, a medication used to treat wounds] dressing to wound bed, cover with Mepilex AG [antimicrobial foam dressing] and secure with transparent dressing, three times a week and as needed for soilage ...Apply Nystatin powder to abdominal folds topically two times a day for affected areas ...Resident to have weekly head to toe skin assessments completed. Nurse must complete the skin observation tool."<br><br>Resident C's Treatment Administration Record (TAR) for November 2020 indicated the following orders were not documented as completed:<br>Order to cleanse folds everyday with warm soapy water and dry well, apply nystatin powder to folds had not been completed on November 2, 6, 7, or 16.<br>Order to cleanse right lower abdominal wound with sterile water, pat dry. Skin prep to periwound. Calcium AG [Alginate, a medication used to treat wounds] dressing to wound bed, cover with Mepilex AG [antimicrobial foam dressing] and secure with transparent dressing, three times a week had not been completed on November, 1, 3, 7, and 9.<br>Order to apply Nystatin powder topically to folds two times a day for affected areas had not been completed for the day shift on November 6, 7, | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | and 16, and had not been completed on the night shift for November 1, 2, 5, 6, 10, 12, 17, and 18.<br><br>The resident's weekly skin assessments were completed with no refusal of care on October 29, November 3, 10, and 16.<br><br>Resident C's nursing progress notes were reviewed from September 30 to October 11. The progress notes lacked any resident refusal of care except for a weight check on 10/5/20.<br><br>A progress note, dated 10/12/2020, indicated, "...patient refused peri care. Visual assessment resident had green drainage from abdomen to floor, with odor..." and Resident C was sent to the Emergency Department (ED).<br><br>There were no progress notes, or additional documentation of follow up with the Resident C related to her allegations of neglect or mental health.<br><br>There were no progress notes, or additional documentation of the resident's education for refusal of care.<br><br>A care plan, dated 10/7/20, indicated, the resident "...is resistive to care, refusing meals, bed baths, wound dressing changes r/t major depressive disorder..." No new interventions were added after her 10/12/20 hospital stay, or the 10/27/20 EMS fire report.<br><br>A care plan, dated 10/7/20, indicated, the resident had "... Potential for Skin/tissue integrity r/t [related to] impaired sensory bedfast, incontinence, impaired bed mobility, potential friction and shear. Hx [history] of refusing care..." No new interventions were added after | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | her 10/12/20 hospital stay, or the 10/27/20 EMS fire report.<br><br>The hospital summary, dated 10/12/2020, indicated, "...chief complaint: wound infection with maggots... [patient is] bedbound presented to the ED with suspicion for wound infection after nursing at the ECF (extended care facility) found maggots in her panniculitis wound... Patient with allegations of neglect at the ECF ....She was very tearful and at one point stated that she would harm herself if she were to go back to the facility...Assessment and Plan: Problem 1: Sepsis 2/2 panniculitis... Patient reports that they found maggots at the ECF. Erythema (redness of the skin) warmth and purulent drainage (thick with a yellow, green or brown color, with a pungent, strong, foul, fecal or musty odor)... abx (antibiotic) coverage broadly start Vanc/ceftriaxone (a combination antibiotic used to treat bacterial infections) and flagyl for wound care... Problem 7: Alleged neglect... Patient with allegations of neglect at the ECF reporting that they do not change her wound dressing...."<br><br>During an interview, on 11/20/20 at 1:46 p.m., the EMS Shift Supervisor indicated, he was called as back up to the facility on 10/27/20 to assist with Resident C's care and transfer to a bariatric bed. He was told by the crew, upon their arrival the room was so filthy that Resident C was inaccessible, so they cleaned and mopped the room. It appeared that housekeeping had been totally absent. Resident C was lying on her stomach in a standard size bed, which was much too small for her. EMS Shift Supervisor indicated he had been on several previous runs for this resident and had reported to staff that Resident C needed to be in a bariatric bed. As the crew lifted Resident C to her knees, where she | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | could help support herself, the nursing staff and EMS staff cleaned her up. The pad she had been laying on was grossly soiled with brown and green drainage, her sheets were also littered with debris, and there were maggots crawling on her, and [nursing] staff indicated there had been maggots on a previous occasion. The EMS Shift Supervisor reported his concerns to the facility administrator.<br><br>On 11/20/20 at 2:09 p.m., EMS Shift Supervisor provided a copy of the Fire Report. The Fire Report, dated 10/27/20, indicated EMS arrived at 9:56 a.m., and left at 11:02 a.m. The Fire Report summary indicated: "...arrived to find [crew with Resident C who is alert and oriented x 4 (person/place/time/situation)] assisting with pt [patient] moving to bariatric bed... room unattended to and in disarray... [crew] assisted further with housekeeping by cleaning out trash, sweeping and mopping floor for facility. On arrival [patient] lying on old soiled blankets, as [patient] moved found food debris and maggots crawling on bed... [EMS Officer] completed investigation on [patient] care and facility. Spoke with facility manager and indicated of pending investigation regarding [patient] care and housekeeping concerns ...."2. On 11/18/20 at 9:46 a.m., Resident B was observed with the room door open. The door sign indicated Resident B was in isolation/quarantine. The resident indicated he was feeling well and had a good day so far. A drainage bag was observed attached to the bedrail, hanging below the abdomen, with tubing running from under the bed covers to the bag. A brown liquid was observed in the bag.<br><br>On 11/18/20 at 11:00 a.m., a review of Resident B's medical record indicated, diagnoses included, | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | but were not limited to a cutaneous (pertaining to skin) abscess (infection) of the abdominal wall, fistula (a passage between an opening in the skin and a body surface) of the intestine, ileostomy (an opening in the skin with a pathway to allow solid waste to exit the body), and severe protein/calorie malnutrition.<br><br>On 6/12/20 at 2:51 p.m., the most recent dietary note indicated, Resident B continued a Regular diet with pleasure foods (51-100% by mouth for most meals). Resident B was on TPN (total parental nutrition, intravenous nutrition) which provided 1548 calories and 100 g (grams) protein daily. PO (oral) intake and TPN averaged about 2100- 150 g protein/day with PO of approximately 51%. Weight was stable this month.<br><br>The October Medication Administration Record (MAR) contained a one time order on 10/24/20 for "Change central line [intravenous] dressing today, one time only."<br><br>The medical records indicated from 11/09/20 thru 11/12/20 Resident B had numerous critical lab values, which included potassium, sodium, and CO2 (carbon dioxide) reported to the NP (Nurse Practitioner). On 11/09/20 at 6:03 p.m., a progress note indicated, "[Name of MD] in house this morning; reviewed resident's labs and d/c'd [discontinued] convergence orders, replacing with oral KCL [potassium] 40 meq [dose measurement] qd [every day]. Resident's labs faxed to [Name of Pharmacy] for appropriate TPN formulation to address electrolyte imbalances. Each day medication adjustments were made, and labs were rechecked the following day." The resident continued to decline until 11/13/20 when the order was given to | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | transfer to the ER.<br><br>A physician progress note, on 11/13/2020 at 4:49 p.m., indicated they were called by nursing for continued decline. The resident had an elevated CO2 (carbon dioxide) and low potassium level. The resident was declining particularly in mental status per nursing. The resident was barely responsive, required much stimuli to even get him to open his eyes. The resident was to transfer to ER (emergency room).<br><br>There were no progress notes indicating Resident B had left the facility or for Resident B's readmission to the facility. There was not an admission assessment documented for this re-admission. Resident B's Physician Orders, dated 11/17/20, only contained a standardized order set. They were not inclusive of medications and treatments. There were no dressing change orders, no intravenous order, or diet orders.<br><br>A progress note dated 11/18/20 at 10:36 a.m., by Social Services indicated Resident B had been admitted to hospice care.<br><br>The November TAR (treatment administration record) indicated, "left lower abdomen, cleanse with sterile water, pat dry, skin prep peri [around] wound, apply xeroform (specialized dressing) and cover with bordered gauze. Every night and prn [as needed]."<br>The documentation for 11/10/20 indicated the resident's dressing had not been changed. On 11/11/20 the documentation indicated the resident refused. On 11/13/20 there was no signature, the record was blank for that day, | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | indicating not done. On 11/14/20 and 11/15/20, the TAR indicated the resident was hospitalized.<br><br>During an interview, on 11/18/20 at 11:25 a.m., the Director of Nursing (DON) indicated Resident B had returned from the hospital on 11/17/20. Copies of Resident B's wound care notes, hospital records, and current orders were requested, at that time.<br><br>During a telephone interview, on 11/18/20 at 11:30 a.m., the (Name of Hospital) Social Worker indicated, the hospital physician, and the medical transport team (brought resident to hospital) both had concerns with the condition of the resident upon transport and admission to the hospital. Resident B's abdomen was covered in intestinal contents with old clotted blood and old bandages. The resident had reported to the physician his bandages were not changed daily, at the facility. The resident had experienced a seizure in the ER (emergency room) due to an IV (intravenous line) infection with sepsis (systemic infection). The resident was in shock, possibly due to dehydration.<br><br>On 11/19/20 at 09:00 a.m., the ED provided a copy of Resident B's Hospital Surgery Consult Note, dated 11/13/20 at 9:32 p.m. The complete hospital discharge record was requested but not provided. This Physician's report indicated, " ... [Named Resident B] ...presents due to lab abnormalities from his ECF [extended care facility] ...arrived hypotensive [low blood pressure] and tachycardic [rapid heart rate] ... his abdomen was covered in intestinal contents with old clotted blood and old bandages ...he has a persistent area of bleeding on his abdominal wall...." | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | A second Surgery Consult note indicated, " ...Overnight patient coded [heart stopped], CPR [cardiopulmonary chest compressions] x1, 8 shocks [electric shock to heart] ...Cardiology consulted ...Mg [magnesium] Phos [phosphorous], and potassium was repleted [very low levels] ...Patient's brother was called ...decision made to make patient DNR [do not resuscitate] ...."<br><br>On 11/18/20 at 3:00 p.m., the following late note was entered into Resident B's record by the Wound Nurse: "Created Date: 11/18/2020 15:00:34 [3:00 p.m.], On 11/17/2020 at approximately 1830 [6:30 p.m.], Resident noted with abdominal surgical fistula and ileostomy. Foul odorous abdominal contents and feces noted excreting from fistula. Excoriation noted to surrounding skin d/t frequent spontaneous leaks from wound manager. Resident has continuous generalized pain as well as wound pain. PRN [as needed] meds given per Hospice order with noted effectiveness. Cleansed area with mild soap and water, rinsed with water and pat dry. Applied house barrier cream to excoriated areas per MD [medical doctor] order. Resident was relieved at this time. Resident noted with bruises to BUE [bilateral upper extremitie]) from I.V. [intravenous line] while in hospital. Dried scab noted to left abdomen. Left thigh noted with multiple scabs from previous surgical procedure. Resident is resting in bed with eyes closed at this time...."<br><br>On 11/19/2020 at 09:00 a.m., during an interview, the DON indicated she would have to look at the policy to see if the resident should have been assessed upon return from the hospital. She would have to check progress notes to see when the resident returned to the facility. | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | She did not find an assessment for the transfer out to the hospital.<br><br>On 11/19/2020 at 9:20 a.m., the ED provided a copy of the admission policy and indicated all residents should have been assessed on admission.<br><br>On 11/19/2020 at 11:20 a.m., upon request, the ED provided printed copies of Resident B's weekly skin assessments, and admission skin assessment for review. Assessments, dated 10/29/2020, 11/03/2020, 11/10/2020, and 11/17/2020, were all signed by the Wound Care Nurse on 11/18/2020. An Admission Skin evaluation, dated 10/22/2020 (original admission date), indicated Resident B had a surgical wound, on his abdomen, identified as an abdominal fistula ileostomy.<br>3. On 11/18/20 at 11:59 a.m., Resident D's medical record was reviewed. A list of medical diagnoses included, but was not limited to, osteomyelitis of the vertebra (bone infection of the spine), need for assistance with personal care, reduced mobility, and type 2 diabetes.<br><br>A physician order, dated 7/30/20, indicated Vancomycin (an antibiotic used to treat serious bacterial infections) was to be given intravenously (delivered directly into the blood stream) for a bacterial infection of the resident's spine.<br><br>A physician order, dated 10/6/20, indicated nursing staff was to clean a left foot wound and to cover the wound with a new dressing (bandage for wounds) daily. The record indicated the treatment was to continue from 10/6/20 to 10/13/20. | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | The record lacked a nursing, progress, or assessment note that referred to the wound.<br><br>The record lacked documentation of wound assessment for 10/6/20, and 10/11/20 through 10/13/20.<br><br>The record lacked documentation of a dressing change or wound care on the following dates 10/6/20, 10/9/20, 10/11/20 through 10/13/20.<br><br>A progress note, dated 10/20/2020 at 1:00 p.m., indicated wounds were found on the side of the resident's right foot and on the bottom of his left foot.<br><br>A physician's order, dated 10/20/20, indicated the nursing staff were to assess, clean, and apply a new dressing to the resident's right and left foot wounds daily.<br><br>The record lacked documentation of a dressing change for the resident's right and left foot for the following dates: 10/23/20 to 10/31/20, 11/1/20 to 11/3/20, and 11/7/20.<br><br>A physician order, dated 11/10/20, indicated nursing staff were to assess, clean, and apply a new dressing to the resident's right and left foot wounds every Monday, Wednesday, and Friday. The record lacked documentation of a dressing change or wound care to the resident's left foot on 11/16/20. The record lacked documentation of a dressing change or wound care to the resident's right foot on 11/16/20 and 11/18/20.<br><br>On 11/19/20 at 11:25 a.m., the DON provided a current policy, dated 05/30/2019, titled" Skin Care and Wound Management Overview." This policy indicated, " ...Each resident is evaluated | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | upon admission and weekly thereafter for changes in skin condition. Resident/patient skin condition is also re-evaluated with change in clinical condition, prior to transfer to the hospital and upon return from the hospital...."<br><br>This Federal tag relates to Complaint IN00341693.<br><br>3.1-37 | | | |
| F 0880 SS=F Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review. | | | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>Based on observation, interview, and record review, the facility failed to ensure staff followed CDC guidance for infection control procedures to protect residents from the COVID-19 virus through the use of personal protective equipment (PPE), hand hygiene, and social distancing, for 22 of 22 residents on a COVID-19 isolation unit, (Residents: E, F, G, H, J, K, L, M, N, P, Q, R, S, T, U, V, W, X, Y, Z, AA, and BB), a resident on isolation (Resident D), and had the potential to effect 84 of 84 residents residing in the facility.<br><br>Findings include:<br><br>On 11/18/20 at 9:34 a.m., during an interview, Licensed Practical Nurse, (LPN) 3 indicated, the hall was a "yellow" (unknown COVID-19 status) COVID-19 isolation unit. All the residents on that hall had been exposed to COVID-19 through a housekeeper who tested positive for the virus and were therefore placed on droplet/isolation precautions.<br><br>On 11/18/20 from 10:45 a.m., until 11:20 a.m., a tour of the yellow COVID-19 isolation unit was conducted, and the following was observed:<br><br>1. At 10:47 a.m., Certified Nursing Assistant, (CNA) 8 was observed as he supervised residents outside on a smoke break. He stood less than 6 feet away from Resident (E), and his face mask was pulled down below his chin. CNA 8 leaned over Resident E, took change from the resident's hand, and entered the building without pulling his face mask up. He walked down the hall and entered Resident E's room without performing | F 0880 | **A.Specific/Immediate:**<br>**Immediately implement specific plan for resident/residents/area/others identified in the deficiency to correct.**<br>**1.The Director of Nursing / IP / designee will ensure the resident/residents affected has been isolated in Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Ensure all staff are aware of who is on isolation and appropriate signage implemented.**<br>**2.2. The Director of Nursing / IP / designee will ensure all staff are re-educated on proper use of PPE while in resident care areas, proper hand hygiene while caring for residents, and proper disposal of PPE.**<br>**Policy / Procedure - Criteria for Covid 19 Isolation**<br>**1.. The Director of Nursing / IP / designee will ensure resident/residents participating in communal dining or activities are social distancing and wearing face covering. If resident cannot tolerate face covering, ensure social distancing and education.** | 12/16/2020 |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | hand hygiene and did not put on a gown or gloves. He exited the room, did not perform hand hygiene, and did not pull his face mask up to its proper position until he exited the yellow hall. CNA 8 continued down the hall to the front of the building where he used a communal vending machine to purchase a soda. He walked back to the yellow unit, and exited though the back door to give the soda to Resident E.<br><br>2. At 10:53 a.m., Housekeeper 9 was observed as she exited Resident G's room wearing a gown and gloves. She removed the gown and gloves in the hallway and placed the soiled PPE in the trash bin of the cleaning cart. She did not perform hand hygiene. She put on a new gown and gloves, rummaged through the cart and gathered supplies. She pulled her gown up to place a set of keys in her pants pockets and bent over the cleaning cart which allowed her gown to touch the surface of the cart several times. She entered Resident H's room at 10:56 a.m. At 10:58 a.m., she exited Resident H's room still wearing her PPE. She removed her gown and gloves in the hallway and placed the soiled PPE in the cleaning cart trash bin of the cleaning cart.<br><br>3. At 11:14 a.m., Resident J's call light was illuminated. Social Service Assistant (SSA) 5 knocked on the door, entered the room, and closed the door behind her. SSA 5 did not perform hand hygiene or put on PPE before entering the room. She exited the room and did not perform hand hygiene. She walked to the nurses' station and used the copier.<br><br>During an interview, at 11:16 a.m., SSA 5 indicated she did not need to put on a gown or gloves to enter resident rooms if she was not performing resident care, even for a yellow | | **Ensure all care giving staff are trained on when and how to social distance and encourage application of face coverings for the residents. Follow CDC and facility policy.**<br>**IN Covid 19 Back on Track Guidelines - updated**<br>**1. The Director of Nursing / IP / designee will ensure staff are properly wearing facial coverings while in facility/resident care areas. Follow CDC and facility policy.**<br>**2.The Director of Nursing / IP / designee will ensure staff are properly disposing of PPE. Follow CDC and facility policy.**<br>**3.The Director of Nursing / IP / designee will ensure staff are practicing hand hygiene as put forwards by CDC and facility policy. The Director of Nursing / IP / designee will re-train all staff on proper hand hygiene.**<br><br>**B. Systemic**<br>**1). A root cause analysis (RCA) was conducted by the company Division (Consultant) Infection Preventionist (IP), with input and review from the Medical Director, IP, Executive Director, Director of Nursing, Assistant Director of Nursing and Regional Director of Clinical Operations to determine the root cause resulting in the facilities Infection Control citation.** | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | isolation unit.<br><br>At 11:18 a.m., SSA 5 entered Resident K, and L's room without performing hand hygiene or putting on PPE. At 11:19 a.m., she exited the room, did not perform hand hygiene, and walked to the front of the building and entered the Staff Development conference room.<br><br>4. At 11:20 a.m., Housekeeper 9 was observed at the front of the dining room hallway intersection. She pulled the open trash bag out of its liner. The trash bag was observed to be full and included several spoiled PPE gowns. She placed the trash bag on the floor and pushed the trash down to compact the contents and tied the bag closed as several staff and residents passed through the hall.<br><br>5. On 11/19/20 at 8:54 a.m., Resident H was observed in the yellow COVID-19 isolation hall. He came out of his room and looked up and down the hallway. He indicated he was looking for someone to help get him some coffee. No staff was observed on the hall or at the nurses' station. Resident H wheeled himself to the unsupervised hall-tray cart and reach up to pour himself a cup of coffee. He did not perform hand hygiene before touching the machine.<br><br>On 11/19/20 at 9:00 a.m., during an interview, LPN 3 indicated, staff were required to assist residents to get coffee, and residents on the isolation hall should not be touching the coffee dispenser. LPN 3 indicated the coffee dispenser was still in use at that time and may have been used again after the resident touched it, which had the potential to spread infection.<br><br>On 11/19/20 at 9:23 a.m., during an interview, | | **a). The Leadership team failed to provide education to the facility nursing staff on the policy and procedure for Criteria for Covid – 19 Isolation The facility leadership team failed to make facility rounds / observations and enforce corrections noted to be deficient infection control observations**<br>**b). The solutions and systemic changes developed by the Division (Consultant IP), DON, ADON and facility IP include: The Director of Nursing / IP / designee will ensure the resident/residents affected has been isolated in Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Ensure all staff are aware of who is on isolation and appropriate signage implemented.**<br>**Policy / Procedure - Criteria for Covid 19 Isolation**<br>**The Director of Nursing / IP / designee will ensure resident/residents participating in communal dining or activities are social distancing and wearing face covering. If resident cannot tolerate face covering, ensure social distancing and education. Ensure all care giving staff are** | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | the Executive Director, (ED) indicated, all staff who went into yellow rooms should have put on PPE, gown and gloves, and should have performed hand hygiene before going into each room. Staff should have monitored the coffee dispenser, to prevent any resident from touching it, and so they would be aware if a resident did touch it, it could be bleached for disinfection.<br>6. On 11/18/20 at 9:15 a.m., during a tour of the building with the Maintenance Supervisor, the Housekeeping Supervisor entered a back door off the facility, adjacent to the kitchen, and proceeded to walk down the hall, past the dining room. He was not wearing a face mask.<br><br>On 11/18/20 at 9:18 a.m., during an interview, the Housekeeping Supervisor indicated he should have been wearing a face mask when he entered the building.<br><br>7. On 11/18/2020 at 9:36 a.m., the Maintenance Supervisor open the door to the kitchen. Dietary Employee 13 was observed, as she prepped food with her face mask under her chin. The Maintenance Supervisor indicated Dietary Employee 13 should have been wearing her mask over her mouth and nose. He then directed her to do so. Dietary Employee 13 repositioned her mask from her chin, to cover her mouth and nose. She then continued working with the food prep. She did not wash or sanitize her hands.<br><br>8. On 11/18/20 at 10:00 a.m., during an interview the Activity Director indicated she knew staff were supposed to be 6 feet apart for social distancing, but she did not know about residents.<br><br>On 11/18/20 at 10:05 a.m., the Activity Director and Activity Assistant were observed in an activity room, behind the Nurses' Station, seated | | **trained on when and how to social distance and encourage application of face coverings for the residents. Follow CDC and facility policy.**<br>**IN Covid 19 Back on Track Guidelines**<br><br>**The DON, IP, or designated facility leadership will conduct full / all department facility rounds / observations at a minimum of daily: observe that the staff ensure residents in droplet precautions remain in their room during the Covid 19 pandemic for the MD ordered amount of time and enforce corrective measures and education if deficiencies are observed**<br>**2). The DON, IP Nurse and Division (Consultant) IP reviewed the LTC Infection Control Self-Assessment. Changes were made to so the assessment would now be an accurate reflection of the facility. This assessment will be submitted with the DPOC documentation.**<br><br>**C. Training:**<br>**1).Per the LTC infection control assessment review and revision by the Division (Consultant) IP, facility IP and DON. The following training needs were identified and implemented by the Division (Consultant) IP to** | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | at a table with 4 unidentified residents, playing cards. There were 2 more unidentified residents at the opposite end of the table seated side by side. None of the 8 people were social distanced. The card players were handing cards back and forth, touching in the exchange of the game.<br><br>On 11/18/20 at 10:34 a.m., during a second observation, the 2 unidentified residents at the opposite end of the table had left the activity room. The 4 unidentified residents, and 2 employees continued the card game. They remained seated next to one another at the table.<br>9. During an observation on 11/19/20 at 11:18 a.m., Certified Nursing Assistant (CNA) 20 and CNA 21 were observed delivering cups of water to residents on the yellow hall (a hallway designated to house residents who may be at risk for developing COVID-19 or who have been exposed to a COVID-19 positive person). The CNAs were observed going into, and coming out of, more than eight resident rooms on the isolation hallway. The CNAs did not use hand sanitizer or put on personal protective equipment (PPE) before entering any resident rooms. The CNAs did not use hand sanitizer when exiting any of the resident rooms. During an interview with the CNAs, they indicated, they were aware all the residents who resided on the yellow hall were on transmission-based precautions (precautions taken to help prevent the spread of disease). The CNAs acknowledged every resident's door had a sign on it that indicated they should use hand sanitizer and put on PPE before they entered a resident's room. The CNAs indicated they did not know they should use hand sanitizer or put on PPE to deliver water to residents on the yellow zone.<br><br>10. On 11/19/20 at 11:20 a.m., CNA 19 was | | **the facility IP and DON with training resources and polices provided and submitted as part of the DPOC documentation.**<br>**1.Infection Surveillance the facility staff can demonstrate knowledge of when and to whom to report communicable diseases, healthcare associated infections and potential outbreaks. The facility has a current plan of correction in progress.**<br>**Hand Hygiene- the facility has hand hygiene policies to promote preferential use of ABHR, personnel performance of hand hygiene. The facility has a plan of correction in progress.**<br>**Standard Precautions Tracer gloves are changed and hand hygiene performed before moving from a contaminated body site to a clean body site during care, PPE is appropriately discarded after resident care, prior to leaving the room, followed by hand hygiene. The facility has a plan of correction in progress.**<br>**Transmission Based Precautions - hand hygiene is performed before entering a resident care environment, gloves and gowns are donned upon entry into the environment of resident on precautions, gloves and gowns** | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | observed exiting the room of a resident on transmission-based precautions. CNA 19 did not use hand sanitizer after he exited the resident's room. The CNA was then observed to go into another resident's room, also on transmission-based precautions. CNA 19 did not use hand sanitizer or put on PPE before he entered the resident's room. The CNA was observed from the hallway, through an opened resident room door. CNA 19 moved a vital signs supply cart, opened and closed a bathroom door, and assisted Resident D with his walker. The CNA was not wearing PPE when he was observed inside the resident's room. CNA 19 did not clean the vital signs equipment when he removed it from Resident D's room. When CNA 19 exited Resident D's, he did not use hand sanitizer. During an interview, CNA 19 indicated he went into Resident D's room, and put on a gown that was hung behind the resident's door. The CNA declined to comment when asked if he should have used hand sanitizer when exiting a resident's room and whether he should have used hand sanitizer and put on a new gown and gloves prior to entering Resident D's room.<br><br>11. On 11/19/20 at 11:26 a.m., Resident N was observed walking in the yellow hall with CNA 18. A sign on Resident N's door indicated he was in transmission-based precautions. Resident N wore a face mask that covered his mouth but did not cover his nose. CNA 18 wore an N95 face mask and a face shield. Neither the resident nor the CNA wore a gown or gloves while walking in the hall. Resident N and CNA 18 were closer than 6 feet apart.<br><br>A policy titled, "Nursing Facility COVID-19 Plan" dated updated 8/12/20, was provided by the Director of Nursing (DON) on 11/19/20 at 9:00 | | **are removed and properly discarded and hand hygiene is performed before leaving the resident care environment. The facility has a plan of correction in progress.**<br>**Disposing properly of PPE after use.**<br><br>**2). Per the RCA completed by the Division (Consultant) IP, Medical Director, IP, Executive Director, Director of Nursing, Assistant Director of Nursing and Regional Director of Clinical Operations, the following training needs were identified and implemented by the Division (Consultant) IP to the facility IP and DON with training resources and polices provided and submitted as part of the DPOC documentation.**<br><br>**The Director of Nursing / IP / designee will ensure the resident/residents affected has been isolated in Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Ensure all staff are aware of who is on isolation and appropriate signage implemented.**<br>**Policy / Procedure - Criteria for Covid 19 Isolation** | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | a.m. The DON indicated this was the current policy being used by the facility at this time. The policy indicated, "All non-dedicated health equipment such as VS [vital signs] monitoring equipment are to be cleaned with appropriate disinfectant between all residents." The policy indicated, a person under investigation (PUI) as, "close contact with a person who is under investigation for 2019-nCoV (COVID-19) while that person was ill ...PUIs should be asked to wear a surgical mask as soon as they are identified and be evaluated in a private room with the door closed ...Health care personnel entering the room should use standard, contact, droplet, and airborne precautions".<br><br>A policy titled, "Criteria for COVID-19 Isolation" dated revised 9/21/20, was provided by the DON on 11/19/20 at 9:00 a.m. The DON indicated this was the current policy being used by the facility at this time. The policy indicated, "At risk for COVID-19 Unit [yellow unit or yellow hall]. This unit will be used for residents who may be at risk for developing COVID-19, but not showing signs and symptoms, etc. Admission Criteria: 2. Any resident who may have been exposed. Process for "At Risk" unit: 2. Full PPE will be used while working on the unit. Full PPE consist of N95 mask, gloves, gown, and eye covers. 4. Gowns and gloves must be changed out between residents. 5. N95 will be changed out after providing resident care and exiting the resident room. 6. Face shield/ goggles will be cleaned between rooms when providing resident care. 7. Hands will be washed and or sanitized prior to entering a resident's room and upon exiting the room."<br><br>The CDC Guidance: "How COVID-19 Spreads", updated 10/28/20, indicated, "People who are | | **The Director of Nursing / IP / designee will ensure resident/residents participating in communal dining or activities are social distancing and wearing face covering. If resident cannot tolerate face covering, ensure social distancing and education. Ensure all care giving staff are trained on when and how to social distance and encourage application of face coverings for the residents. Follow CDC and facility policy.**<br>**IN Covid 19 Back on Track Guidelines - updated 10/20/2020**<br>**The DON, IP, or designated facility leadership will conduct full / all department facility rounds / observations at a minimum of daily: observe that the staff ensure residents in droplet precautions remain in their room during the Covid 19 pandemic for the MD ordered amount of time and enforce corrective measures and education if deficiencies are observed**<br><br>**D. Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained.**<br>**The DON, IP, or designated facility leadership will conduct full facility / all department rounds / observations at 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | physically near (within 6 feet) a person with COVID-19 or have direct contact with that person are at greatest risk of infection ... Some infections can be spread by exposure to virus in small droplets and particles that can linger in the air for minutes to hours ... Respiratory droplets can also land on surfaces and objects. It is possible that a person could get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or eyes ...Stay at least 6 feet away from others, whenever possible. This is very important in preventing the spread of COVID-19. Cover your mouth and nose with a mask when around others. This helps reduce the risk of spread both by close contact and by airborne transmission. Wash your hands often with soap and water. If soap and water are not available, use a hand sanitizer that contains at least 60% alcohol".<br><br>"COVID-19 LTC [Long Term Care] Facility Infection Control Guidance Standard Operating Procedure" updated 10/19/20, indicated, "HCP [health care personnel] will wear single gown per resident, glove, N95 mask and eye protection (face shield/or goggles). Gowns and gloves should be changed after every resident encounter with hand hygiene performed. Masks and face shields may be used for the entire shift if not wet or visibly soiled. Gowns and gloves should be changed after every resident encounter. Residents should be wearing masks when within 6 feet of the HCP ...Glove Hygiene: Perform hand hygiene before use of non-sterile gloves upon entry into the resident room for direct care area. Change gloves if they become torn or heavily contaminated. Remove and discard gloves when leaving the resident room or care area. Immediately perform hand hygiene after removal of gloves." | | **minimum of daily for 6 weeks and until compliance is maintained: observe that the staff ensure residents in droplet precautions remain in their room during the Covid 19 pandemic for the MD ordered amount of time and enforce corrective measures and education if deficiencies are observed**<br>**The DON, IP, or designated facility leadership will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices. This will occur for 6 weeks and until compliance is maintained.**<br>**The DON, IP, or designated facility leadership will re-educate all staff on proper hand hygiene, use of PPE while in resident care areas, and disposing of PPE.**<br><br>**E. Quality Assurance and Performance Improvement (QAPI):**<br><br>**The IP Nurse/Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 6 months. The facility through the QAPI program will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no** | |

| 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 | 11/19/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EAGLE CREEK HEALTHCARE CENTER | 4102 SHORE DR<br>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 |
|---|---|---|---|---|
| | Undated CDC guidance titled, "How to Safely Remove Personal Protective Equipment (PPE)" indicated, "Remove all PPE before exiting the patient room except a respirator, if worn."<br><br>3.1-18(b)(1) | | **less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.** | |