STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENCES AT COFFEE CREEK	2300 VILLAGE POINT, CHESTERTON, , 46304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00456116. Complaint IN00456116 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey date: April 1, 2025 Facility number: 014469 Residential Census: 105 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/3/25.	R 0000	Residences at Coffee Creek (the “Provider”) submits this Plan of Correction (“POC”) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider herby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the state of Indiana	

			or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. We are requesting paper compliance for the deficiencies cited.	
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based record review and interview, the facility failed to ensure a resident with a history of Urinary Tract Infections (UTIs) received adequate monitoring related to a delay in treatment for a positive urinary analysis (UA) for 1 of 1 resident reviewed for infection. (Resident C) Finding includes:	R 0240	Resident C was treated at the hospital for the UTI and has returned to the facility. After the survey, all residents' charts that currently had infections were audited to ensure that there was not a delay in treatment. With this particular resident, several attempts were made to contact the resident's attending physician, but due to it being a weekend, the physician was not	04/02/2025

	The record for Resident C was reviewed on 4/1/25 at 9:32 a.m. Diagnoses included, but were not limited to, dementia and anxiety. A Service Plan, dated 2/26/25, indicated the resident had severe cognitive impairment and required constant redirection, assistance with decision making, and the resident had no current behaviors. A Physician's Order, dated 2/27/25, indicated UA's may be obtained as needed for frequent UTI's. Incident charting, dated 3/21/25, indicated Resident B was noted to be in bed with Resident C. Resident B was immediately removed from Resident C's room and both residents were assessed, put on 15 minute monitoring, the family was notified, and the Nurse Practitioner was notified and ordered a urine analysis (UA). An Interdisciplinary Note, dated 3/23/25 at 10:53 p.m., indicated a UA was obtained and the family came in and the resident calmed down. The answering service was called to have anxiety medication refilled and the physician would not refill the medication due to not being the prescribing physician. An Interdisciplinary Note, dated 3/28/25 at 9:45 p.m., indicated		responding. All nursing staff were in-serviced on what actions to take if the physician does not respond timely, including a suggestion to the family to take the resident to urgent care or the ER for treatment. Nursing notes will be audited 5 days a week by the Director of Resident Services or designee to ensure that treatment has been started for any resident that has an infection. This audit will be done until 100% compliance is achieved. Any discrepancy will be documented and discussed at the QA committee. These systematic changes will be in place by 4/2/25.	

UA results were faxed to the physician.

An Interdisciplinary Note, dated 3/28/25 at 10:30 p.m., indicated the resident became very agitated prior to supper and was yelling and screaming at other residents, saying "they never do anything." Staff tried multiple times to redirect the resident and she was still upset.

An Interdisciplinary Note, dated 3/30/25 at 20:44 p.m., indicated the resident became increasingly upset as the shift went on. The resident was pacing back and forth stating "no one is doing anything", tossed picture frame at the nurses' station and threw a vase and broke it. Staff tried to calmly redirect the resident and she continued to yell. She was humming loudly and banging Lysol wipes on the care center. The resident tried to lift a recliner in the TV room, throw a pillow, and was punching the fireplace glass. The aide was able to redirect the resident to her room. The resident's son was called, and he came to sit with the resident. At that time, the family agreed to see the in-house physician instead of the resident's usual physician.

An Interdisciplinary Note, dated 3/31/25, indicated the resident's family came in to calm the resident down. The family

decided to take the resident to the hospital to have her UTI treated. The resident was admitted and given IV antibiotics.

An Interdisciplinary Note, dated 3/31/25 at 6:41 a.m., indicated the daughter-in-law called the facility to notify them the resident was admitted to hospital with a diagnosis of UTI.

During an interview on 4/1/25 at 10:03 a.m., the Executive Director (ED) indicated Resident C was currently out on leave. Resident C had a urine ordered after the incident on 3/21/25 and she did have a positive UA result.

During an interview on 4/1/25 at 11:22 a.m., RN 1 indicated Resident C's urine was positive for infection and she was currently in the hospital receiving intravenous (IV) antibiotics for her infection.

During an interview on 4/1/25 at 12:02 p.m., the ED and Director of Nursing (DON) indicated through the investigative process, they learned that Resident C was the initiator during the incident with resident B and her family indicated she had these behaviors when she had a UTI. That was new information to the staff and the resident was currently in the hospital for her infection. The

facility planned on monitoring the resident for UTI symptoms and adding that to her service plan when she returned to the facility.

During an interview on 4/1/25 at 1:59 p.m., the DON indicated the lab does not do pick ups on the weekends. The urine was obtained from Resident C on 3/23/25 and was ready to be picked up first thing on 3/24/25. They could not reach the physician after the UA was faxed on 3/28/25. There was no documentation to indicate the physician was notified or continued attempts to contact were made after the fax was sent.

Based record review and interview, the facility failed to ensure a resident with a history of Urinary Tract Infections (UTIs) received adequate monitoring related to a delay in treatment for a positive urinary analysis (UA) for 1 of 1 resident reviewed for infection. (Resident C)

Finding includes:

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required constant redirection, assistance with decision making, and the resident had no current behaviors.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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