STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CREEKSIDE VILLAGE	1420 E DOUGLAS RD MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 7, 8, 9,10, & 13, 2025 Facility number: 012329 Provider number: 155784 AIM number: 201002500 Census Bed Type: SNF/NF: 89 Total: 89 Census Payor Type: Medicare: 12 Medicaid: 46 Other: 31 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 1/24/2025	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after February 13, 2025**	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, interview and record review, the facility failed to ensure individual and group activities were provided per individual preferences for 1 of 1 resident reviewed for activities (Resident 11). Finding includes: During an observation, on 1/07/2025 at 11:00 A.M. Resident 11 was observed gazing off into the	F 0679	F679 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice All activity staff have been educated on providing activities that support the physical, mental, and psychosocial well-being of all the residents, giving verbal	02/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erin Ginter	Executive Director	02/06/2025

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	distance while seated in her reclining gerichair. Resident 11's chair had been placed was in the living room area of nursing pod in front of a television. The television was on, but Resident 11 was not watching the television. There was no other activity being provided that included Resident 11. During an observation on 1/08/2025 at 9:34 A.M., Resident 11 was seated in her reclining gerichair in front of the television in the living room area of the nursing pod. Resident 11 was not looking at the television during the observation nor was she involved in any type of activity program. During an observation on 1/09/2025 at 10:20 A.M., Resident 11 was observed seated in her reclining gerichair in the living room area of the nursing pod. She was noted to intermittently talk to no one in particular and was not watching the playing television. During an observation, on 1/10/2025 at 10:01 A.M. Resident 11 was observed lying in bed in her room, looking at the television. During an observation, on 1/10/2025 at 2:01 P.M. Resident 11 was seated in her reclining gerichair in the living room area of the nursing pod, looking out of a window. The record review for Resident 11 was completed on 1/10/2025 at 9:50 A.M. Diagnoses included, but were not limited to: dementia, hypertension, diabetes mellitus, hypothyroidism, depression, anxiety, cognitive communication disorder, brief psychotic disorder and chronic obstructive pulmonary disease. A Quarterly Minimum Data Set (MDS)		reminders to residents regarding activities of interest, providing assistance as needed with activities including independent supply offerings and 1:1 time for those with individualized program needs, encouraging engagement/participation with activities, assisting residents to activities as needed, and following the activity calendar. Activity director to audit activity care plans to ensure activity preferences are met. Activity Director to review care assist activity documentation routinely to ensure documentation matches active and passive participation performed by the residents. For group, independent and 1:1 performed activities. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken All residents that reside in the facility have the potential to be affected by the deficient practice. All activity staff have been educated on providing activities that support the physical, mental, and psychosocial well-being of all the residents, giving verbal reminders to residents regarding activities of interest, providing assistance as needed with activities including independent supply offerings and 1:1 time for those with individualized program	

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	assessment, dated 11/20/2024, indicated Resident 11 was severely cognitively impaired. An Annual MDS assessment, dated 9/3/2024, indicated Resident 11's activity preferences indicated it was very important for her to listen to music she liked, somewhat important for Resident 11 to read, be around pets, keep up with the news and participate in religious practices. Resident 11 indicated it was not very important to do things with groups, do past favorite activities or go outside. A current Care Plan, revised on 12/3/2024, indicated Resident 11 was identified with a potential for psychosocial well-being issues. Interventions included, but were not limited to: encourage activities of interest such as people-watching, musical activities, watching western movies and TV game shows. A Preferences for Routines and Activities form, dated 9/9/2024, indicated the resident was non-responsive to questions on the form. An Activity Assessment, dated 9/9/2024, indicated the resident was non-responsive to questions on the form. During an interview, on 1/10/2025 at 1:33 P.M., the Activities Director indicated Resident 11 was scheduled for one-to-one activities on Mondays, Wednesdays and Fridays with an activity aide. These activities consisted of playing games on an electronic tablet or touching a sensory blanket. The Activity Director indicated there were no activity participation documented for Resident 11 for the months of November 2024, December 2024, and up to and including January 10th, 2025. The Activities Director indicated the 1:1 activities should have been documented by the activity's		needs, encouraging engagement/participation with activities, assisting residents to activities as needed, and following the activity calendar. Activity director to audit activity care plans to ensure activity preferences are met. Activity Director to review care assist activity documentation routinely to ensure documentation matches active and passive participation performed by the residents. For group, independent and 1:1 performed activities. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur All activity staff have been educated on providing activities that support the physical, mental, and psychosocial well-being of all the residents, giving verbal reminders to residents regarding activities of interest, providing assistance as needed with activities including independent supply offerings and 1:1 time for those with individualized program needs, encouraging engagement/participation with activities, assisting residents to activities as needed, and following the activity calendar. Activity director to audit activity care plans to ensure activity preferences are met. Activity Director to review care assist activity documentation routinely to ensure documentation	

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	aide for Resident 11. On 1/13/2025, at 9:00 A.M., the Administrator indicated the facility did not have an activity program policy. 3.1-33(a)		matches active and passive participation performed by the residents. For group, independent and 1:1 performed activities. Non-compliance with education to result in disciplinary action up to and including termination. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed; Activities director/designee will complete the Social Enrichment Program QAPI tool weekly for 4 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview and record review, the facility failed to assess a resident's skin or notify the Physician of the need for a treatment timely for 1 of 3 residents who were reviewed for a skin condition (Resident 30). Finding includes: During observations on the following dates, Resident 30 had multiple scratches across the top of his head in various stages of healing. Six of the	F 0684	**F684- Quality of Care** It is the practice of this facility to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive plan of care, and residents' choices. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	02/13/2025

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	scratches had thick scabs covering part of the scratches: 1/7/2024 at 11:07 A.M., 1/8/2024 at 2:06 P.M. and 1/9/2024 at 9:35 A.M. During an interview with CNA 7, completed on 1/9/2025 at 9:43 A.M., she indicated Resident 30's scratches on the top of his head were from the resident scratching himself. CNA 7 indicated Resident 30 refused nail care often and it was the family's preference that the family provided Resident 30's nail care. Resident 30's record review was completed on 1/9/2025 at 10:50 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, chronic diastolic (congestive) heart failure, cerebral palsy, schizophrenia, dysphagia, oropharyngeal phase and major depressive disorder. Resident 30's record lacked documentation that a weekly skin assessment had been completed by a nurse. A current Physician's order dated, 12/2/2024, indicated the resident received Hospice services. A Visit Note Report from the Hospice nurse, dated 1/7/2024 at 4:16 P.M., indicated the resident had been assessed by the Hospice nurse, but the scratches were not included in the documentation. During an interview on 1/9/2024 at 2:06 P.M., the Assistant Director of Nursing (ADON) indicated Resident 30's scratches had not been reported to her prior to 1/9/2024 and she did not know how long the scratches had been there present. The ADON indicated she was responsible for wounds follow up in the building and she had completed an assessment upon finding out about Resident		**practice:** Resident # 30 skin was assessed. Skin events completed; treatment order obtained for the scratches. MD/NP assessed resident for itchiness and ordered a PRN for 14 days. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. A facility skin sweep was completed by 2.13.25. The DNS/designee will review the past 30 days of Weekly Skin and Vitals for completion and accuracy by 2.13.25. Any discrepancies will be corrected immediately. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The DNS/designee will in-service all nurses on or before 2.13.25 on completing the Weekly Skin and Vitals per schedule and completing a new skin event for any skin impairments. During AM clinical meeting, DNS/designee will audit scheduled Weekly Skin and Vitals observation to ensure completion and accuracy. Any missing observation will be completed by a nurse that day. DNS and nurse managers will	

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	30's scratches. The ADON indicated the resident was itchy but could not say if he had an order for anything to relieve the itching or if Hospice had been notified about his excessive scratching. Resident 30's record lacked the documentation to indicate he had a treatment ordered for itching or that Hospice had been notified of the Resident's itching. He also did not have a Care Plan indicating he had a problem with excessive itching or scratching. On 1/10/2025 at 1:53 P.M. the Regional Clinical Nurse (RNC) provided a policy dated, 5/2022, and titled, "Skin Management Program". The RNC indicated the policy was the one currently used by the facility. The policy indicated, "... Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters and rashes. The licensed nurse is responsible for assessing all skin alterations by the direct caregivers on the shift reported... All newly identified areas after admission will be document on the New Skin Event.... A plan of care will be initiated to include resident specific risk factors and contributing factors with appropriate interventions implemented...." 3.1-37(b)		conduct monthly skin sweeps to identify any unidentified skin areas. Any areas identified will have a skin event completed and treatment order in place as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Skin Management” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If a threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 2.13.25	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on interview and record review, the facility failed to obtain an admission weight and weekly weights of a newly admitted resident that resulted in an undetermined weight loss for 1 of 3 residents	F 0692	**F692- Nutrition/Hydration Status Maintenance** It is the practice of this facility to ensure that residents maintain	02/13/2025

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	reviewed for a weight loss (Resident 62). Finding includes: During an interview on 1/8/2025 at 1:15 P.M., the family of Resident 62 indicated they were worried about the resident's weight because it appeared to the family the resident was losing weight. Resident 62's record review was completed on 1/9/2025 at 3:00 P.M. She was admitted on 11/21/2024 and her diagnoses included, but were not limited to: fracture of left femur, Alzheimer's disease, dementia, anxiety, hypertension and abnormal weight loss. An Admission Minimum Data Set assessment (MDS) dated, 11/27/2024, indicated Resident 62 did not have a swallowing problem, required supervision for meals and weighed 125 pounds. Resident 62's record lacked documentation that she had been weighed upon admission. A Nutrition Observation form was completed by the Registered Dietician on 11/29/2024. The observation form indicated the resident had not been weighed by the facility and the weight used for recommendations was the weight provided from the hospital on 11/15/2024. The resident weighed 125.4 pounds on the hospital discharge paperwork and the dietician recommendations were to weigh the resident weekly. Resident 62's weight was not assessed until 12/2/2024 and she weighed 117 pounds. On 12/15/2024 she weighed 116.4 pounds. These weights indicated a 6.7 percent weight loss in less than 30 days (11/21/2024 through 12/2/2024).wq		acceptable parameters of nutritional status, such as usual body weight or desired body weight range and electrolyte balance, unless the residents clinical condition demonstrates that this is not possible or resident preference indicates otherwise. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #62- MD/NP and family have been notified of resident's weight changes **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All new and readmissions have the potential to be affected. DNS/designee complete an audit of all new and readmissions in the past 30 days to ensure a weight has been recorded upon admission and weekly x4 thereafter. If an omission is noted, the DNS/designee will obtain a weight immediately. DNS/designee will review the weight variance report for the past 30 days. Any weight concerns/ nutritional concerns will be communicated to the MD/NP and Family.	

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	A current Care Plan dated, 11/29/2024, indicated Resident 62 was at risk for weight loss related to behaviors and poor intakes. The goal was for the resident to maintain her weight. Interventions to the Care Plan dated, 11/29/2024, indicated the resident's weight should be monitored and the Physician and family should be notified of significant weight changes. The record lacked documentation the Physician or family had been notified before the resident's weight loss. During an interview on 1/13/2024 at 9:50 A.M., the Director of Nursing (DON) indicated Resident 62 had not been weighed upon admission and the weight recorded in the MDS assessment was from the hospital discharge paperwork the facility received upon the resident's admission. The DON indicated the facility was not able say if the resident had a significant weight loss because the facility was unsure if the weight on the hospital discharge papers was accurate at the time the resident was admitted to the facility. It was the policy of the facility to weigh all new admissions at the time they were admitted and then once a week for four weeks and to follow the Dietician's recommendations. On 1/10/2024 at 1:53 P.M. the Regional Clinical Nurse (RCN) provided a policy dated, 9/2024, and titled, "Resident Weight Monitoring". The RCN indicated it was the policy currently used by the facility. The policy indicated, "... Procedure 1. Upon admission, the resident's weight and height will be measured and recorded in the clinical record. 2. The interdisciplinary team will place the following residents on weekly weights: New admission or readmission for a minimum of 4 weeks... 6. The physician/health care practitioner		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be educated on the “Resident Weight Monitoring” policy by 2.13.25. During Am clinical meeting, the DNS/designee will review new/re admissions to ensure that a weight was obtained and recorded in the medical record. Any omissions will be addressed immediately. The DNS/designee will review the resident weight variance report no less than monthly. Any noted unplanned significant weight loss will be reported to the MD and family. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Weight Monitoring” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If a threshold of 90% is not met, an action plan will be	

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	and resident representative will be notified of unplanned significant weight loss... 8. Any significant unexplained weight loss is considered a change in condition and must be addressed by the Interdisciplinary Team to determine if a new MDS/Comprehensive Assessment is needed. 3.1-46(1)		developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed:** Compliance Date: 2.13.25	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview and record review, the facility failed to follow physician's orders related to enternal feedings and water flushes for 1 of 1 resident reviewed for a gastronomy tube (G-tube) (Resident 27). Finding includes: During an observation on 1/7/2025 at 1:40 P.M., a bottle of Jevity 1.5 (enteral therapy) was disconnected from Resident 27 and hanging on an intravenous line (IV) pole. The bottle of Jevity 1.5 was dated 1/6/2024 and had 200 milliliters (mLs) left in the bottle. During an observation on 1/8/2025 at 10:40 A.M., a bottle of Jevity 1.5 was disconnected from Resident 27 and hanging on an IV pole. The bottle of Jevity 1.5 was dated 1/7/2024 and had 75 mLs remaining in the bottle. During an observation on 1/10/25 at 8:40 A.M., a bottle of Jevity 1.5 was disconnected from Resident 27 and was hanging on an IV pole with 225 mLs still remaining in the bottle. The date on the bottle was 1/9/2024. During an interview on 1/10/2025 at 8:41 A.M.,	F 0693	**F693- Tube Feeding Mgmt** It is the practice of the facility to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Md has been notified that Resident #27 has not received her full enteral feeding or water flushes as ordered. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Any residents with enteral feeding and water flushes have the potential to be affected. DNS/designee will audit the past 30 days of all residents with enteral feeding and/or water	02/13/2025

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	LPN 5 indicated there was 225 mLs remaining in the bottle of Jevity 1.5 and it was normal for Resident 27 to have 200-300 mLs remaining in the bottle in the mornings. The entral feed was shut off at 7 A.M. and the remaining Jevity 1.5 was thrown away. LPN 5 had not charted the amount of Jevity 1.5 given, but instead marked the task complete in the Electronic Medical Record (EMAR). LPN 5 indicated she was not sure if the resident received the correct amount of feeding and calories recommended by the dietician if 200 to 300 mLs of Jevity 1.5 were routinely not administered. In addition, the physician had not been notified when Resident 27 did not receive the full amount of ordered enteral feedings. Resident 27's record review was completed on 1/10/2024 at 9:10 A.M. Diagnoses included, but were not limited to: moderate protein-calorie malnutrition, cerebral infarction, neuroleptic induced parkinsonism, schizoaffective disorder, hemiplegia, epileptic, major depressive disorder, dysphagia, and Parkinson's disease. A Quarterly Minimum Data Set (MDS) assessment dated, 11/27/2024, indicated Resident 27 received 51% or more of calories through tube feedings. A current Physician's order dated, 9/4/2024, indicated Resident 27 was to receive an enteral feeding of Jevity 1.5 daily. The enteral feeding was to run at 85 mLs per hour for 12 hours for a total of 1000 mLs. A current Physician's order dated, 12/11/2024, indicated Resident 27 was to receive 225 mLs of water every six hours. A current Care Plan dated, 1/28/2024, indicated Resident 27 was at risk for complications related		flushes to ensure all the feeding and water flushes were administered as ordered. Any identified concerns will be communicated to the MD and family. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** DNS/designee will educate all nurses on following MD orders for enteral feeding and water flushes by 2.13.25. Daily during the AM Clinical meeting, the DNS/designee will review the EMAR for the enteral feeding residents to ensure that the water flushes and feeding were administered per order. The DNS/designee will round daily on the enteral feeding residents to ensure that the resident are receiving their full enteral feeding amount. Any concerns will be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the	

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	to tube feeding. The goal of the Care Plan was to be free from complications related to enteral feeding. Resident 27 had a Care Plan intervention to give tube feedings and water flushes as ordered. Resident 27's Treatment Administration Record (TAR) for December 2024 and January 2025 indicated the resident did not received 225 mLs water flushes on the following dates and times: - December 18, 2024 at 12:00 A.M. - December 19, 2024 at 12:00 A.M. - December 21, 2024 at 12:00 P.M. - December 23, 2024 at 12:00 P.M. - December 27, 2024 at 12:00 A.M., 6:00 A.M., 12:00 P.M. and 6:00 P.M. - December 30, 2024 at 12:00 A.M. - December 31, 2024 at 12:00 A.M. - January 1, 2024 at 12:00 A.M. - January 2, 2024 at 12:00 A.M. and 12:00 P.M. - January 3, 2024 at 12:00 A.M. and 6:00 P.M. - January 5, 2024 at 12:00 A.M. - January 6, 2024 at 12:00 P.M. - January 9, 2024 at 6:00 P.M. Resident 27's record lacked the documentation a Physician had been notified when Resident 27 had not received her full enteral feeding or water flushes. During an interview with the Regional Clinical Nurse (RCN) on 1/13/2024 at 10:00 A.M., the RCN indicated Resident 27 had not received her water flushes as ordered by the Physician. On 1/10/2025 at 1:53 A.M. the Regional Clinical Nurse (RNC) provided a policy dated, 1/2016, and titled, "Enteral Therapy". The RNC indicated the policy was the one currently used by the facility.		QAPI Audit tool “Enteral Feeding” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If a threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed: 2.13.25**	

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	155784	A. BUILDING 00 B. WING	01/13/2025

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	The policy indicated, "...It is the policy of this facility that the licensed nurse, in cooperation with other healthcare team members, must carefully monitor the resident's response to the enteral feedings and feeding techniques to ensure the attainment of therapeutic goals...A licensed nurse will take, note, and implement physician orders for enteral therapy...." 3.1-44 (a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review the facility failed to ensure a Continuous Positive Airway Pressure (CPAP) machine and tubing was stored properly, the water provided for the machine was sealed while being stored and there was a completed order regarding settings for the machine for 1 of 2 reviewed for respiratory care. (Resident 140) Finding includes: During an observation and interview on 1/7/2025 at 10:27 A.M., Resident 140's CPAP storage bag was on the floor and the mask for the CPAP was under her bed covers. In addition, the sterile water for the machine was from a concentrator bubbler, dated 1/5/25 ,unsealed with about half the water left in the container. The resident indicated the concentrator bubbler container was what the facility used to fill her CPAP machine at night. During an observation and interview on 1/8/2025 at 9:16 A.M., Resident 140's CPAP face mask was on the bed, not stored in the bag. The sterile water container was on the nightstand empty and the resident indicated the water from the container	F 0695	**F695-** **Respiratory/Tracheostomy Care and Suctioning** It is the practice of the facility to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The MD has been notified of resident #140's missing CPAP settings, the physician order has been updated to include CPAP settings. The CPAP machine and tubing is being stored properly and the water is sealed, dated and stored properly. **How other residents having the**	02/13/2025

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	was used last night to fill her CPAP machine. She indicated at home, she used distilled water. During an observation on 1/9/2025 at 9:04 A.M., Resident 140's CPAP machine and mask was lying on the bed, not stored in a bag. During an observation on 1/10/2025 at 9:05 A.M., Resident 140's CPAP mask was lying on the bed not stored in a bag. A record review was completed on 1/9/2025 at 9:51 A.M. Diagnosis included but not limited to: obstructive sleep apnea, anxiety disorder and major depressive disorder. A Physicians Order, dated 1/5/2025, indicated "____BIPAP_____CPAP/setting, on at bedtime and off upon rising." The portion of the order to note the pressure settings was left blank. During an interview on 1/13/2025 at 10:42 A.M., RN 2 indicated the CPAP tubing and mask should have been stored in a bag when not in use. In addition, she indicated the facility used the sterile water from the concentrator bubbler but were to discard any remaining water after the container had been opened because it could not be sealed. RN 2 indicated the order for the CPAP settings was not complete because the settings should have been documented on the order. On 1/13/2025 at 11:43 A.M., the Regional Director of Clinical Services provided a policy titled, "CPAP Therapy," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...10) Verify physician orders, 17) Fill humidifier with distilled or sterile water....." The policy did not indicate how the equipment was to be stored and/or maintained.		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with a CPAP/BiPap have the potential to be affected. The DNS/designee will audit all CPAP/BiPap orders to ensure that settings are included. Any discrepancies will be communicated to the MD and any orders received will be updated. DNS/designee will round on all CPAP/BiPap to ensure that the machine and tubing are stored properly; DNS/designee will also ensure that the sterile water is sealed, dated and stored properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All Nursing staff will be educated on CPAP/BiPap orders, settings, storage, and sterile water use and storage by 2.13.25. Daily during Am Clinical meeting all new orders for CPAP/BiPap will be reviewed, any concerns will be communicated to the MD. DNS/Designee will round daily to ensure that CPAP/BiPap are properly stored and that any sterile water use is sealed, dated and stored properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	3.1-47(a)(6)		**assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "Respiratory Care" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If a threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed: 2.13.25**	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations Based on observation, interview, and record review the facility failed to ensure a newly admitted resident received the influenza vaccine after signing the consent form for 1 out of 5 records reviewed. (Resident 141) Finding includes: During a record review on 1/10/2025 at 2:00 P.M. for Resident 141, the admission influenza vaccination consent form, dated 1/6/2025, indicated she wished to receive the influenza vaccine. The Medication Administration Record (MAR) indicated the influenza vaccine had not been administered to Resident 141.	F 0883	**F883- Influenza and Pneumococcal Immunizations** It is the practice of the facility to ensure that; Each resident/representative receives education regarding the benefits and side effects of the immunization; Each resident is offered the influenza immunization October 1 through March 31 annually, unless medically contraindicated or the resident has already been immunized during this time period; The resident/representative has the	02/13/2025

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	During an interview on 1/13/2025 at 10:00 A.M., the Admissions Director indicated she completed the admission paperwork, including the consents, then uploaded them into the electronic medical record. She indicated the nursing department then took care of providing the vaccinations. During an interview on 1/13/2025 at 11:19 A.M., the DON indicated the facility's process regarding vaccines was as follows: the Infection Preventionist (IP) would ask the resident if they wanted any vaccines, then she would look on CHIRP (Children & Hoosier Immunization Registry Program) to see what vaccines had previously been documented for the resident. If a new admission declined vaccines when asked verbally then signed a consent for the vaccination upon completing the admission paperwork, the resident should have received the vaccine. There was no documentation or explanation given as to why Resident 141 had not received the Influenza vaccination after she had signed a consent requesting the vaccine on 1/6/2025. On 1/7/2025 at 2:00 P.M., the Administrator provided a policy titled, "Influenza (Flu) Vaccination (Resident), revised 8/2021, and indicated the policy was the one currently used by the facility. The policy indicated "...Current and newly admitted residents will be offered the influenza vaccine, unless the immunization is contraindicated, or the resident has already been immunized during this time period....." 3.1-13(a)		opportunity to refuse immunization; The resident's medical record includes documentation at a minimum the education that was provided and whether the resident received the immunization or did not due to medical contraindications or refusal. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #141 has received the influenza vaccine and is documented in the medical record. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All new admissions have the potential to be affected. The DNS/designee will audit all new admissions Influenza consents in the past 30 days to ensure the resident has received or not received the Influenza vaccine per consent. Any concerns will be addressed immediately. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nurse managers will be educated on Influenza Vaccine consents and administration by 2.13.25. Daily during Clinical	

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			meeting, DNS/designee will audit new admissions for vaccine status. DNS/designee will verify a consent has been obtained and obtain orders to administer the vaccine per consent. Any concerns will be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Influenza Vaccine” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If a threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up **By what date the systemic changes will be completed: 2.13.25**	