STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CREEKSIDE HEALTH AND REHABILITATION CENTER	3114 EAST 46TH STREET INDIANAPOLIS, IN 46205

(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. This visit included the Investigation of Complaint IN00446265. Complaint IN00446265 - Federal/state deficiencies related to the allegations are cited at F677. Survey dates: January 8, 9, 10, 13, 14, and 15, 2025 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Census Bed Type: SNF/NF: 109 Total: 109 Census Payor Type: Medicare: 16 Medicaid: 89 Other: 4 Total: 109 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 22, 2025.	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on interview and record review, the facility failed to ensure residents were treated with dignity and respect for 5 of 6 residents reviewed for dignity. (Residents' 13, 24, 37, 43, and 95)	F 0550	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 13, 24, 37, 43, and 95 were not harmed.	02/08/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacia Dawson	Executive Director	02/03/2025

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

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	Findings include: 1. A resident council meeting was conducted on 1/09/25 at 11:05 a.m. The resident attendees in the meeting were the following: Residents' 13, 16, 17, 33, 34, 39, 43, 55, 65, 79, 85, and 94. During the meeting the resident council indicated the staff do not respect and/or maintain the residents' dignity. "The staff need "sensitivity" training. They do not have any "compassion" for the residents. The staff were rude with bad attitudes and disrespectful. During sleeping hours, the staff speak to one another in loud voices along with laughing and yelling down the hallway. The residents overhear inappropriate comments made by the staff as the following, "I don't want to work on 200 hall. I don't get paid enough for this. I only get 20 minutes per resident to assist with getting residents up, so no I don't have time to wash your hair. I am the only one here." The staff turn off call lights and never return to provide the service that had been requested. The residents' feel they do not have a choice if they eat in his or her room or dining room. The staff walk in and report the resident will have to go to the dining room to eat his or her meal. 2. During an interview on 1/09/25 at 9:58 a.m., Resident 24 indicated one of the Certified Nurse Aides (CNAs) had told him to have a bowel movement in the bed, because they did not want to get him up to the toilet. The clinical record for Resident 24 was reviewed on 1/13/25 at 10:00 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 10/25/24, indicated Resident 24 was cognitively intact. 3. During an interview on 1/09/25 at 10:46 a.m., Resident 95 indicated she had issues with the		2. All residents have the potential to be affected. 3. Nursing staff will be re-educated on resident rights policy, to include dignity and customer service. The DON or her designee will complete 10 random observations in resident care areas and during resident staff interactions weekly for 4 weeks, on varying shifts and days, to ensure interactions are respectful, addressing needs, at the right volume level and until 100% compliance is achieved. Observations will then be completed 10 times a month for 2 months and until 100% compliance is maintained, then quarterly on-going. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	third shift turning off her call light and not providing the incontinent care she needed. The clinical record for Resident 95 was reviewed on 1/13/25 at 10:05 a.m. The Quarterly MDS assessment, dated 10/9/24, indicated Resident 95 was cognitively intact. 4. During an interview on 1/9/25 at 2:19 p.m., Resident 13 indicated during shift changes it sounded like there was a "party" going on. The staff talk too loudly, socializing with each other. The staff will turn off the call light and do not do what was initially requested. The clinical record for Resident 13 was reviewed on 1/13/25 at 10:10 a.m. The Annual MDS assessment, dated 11/4/24, indicated Resident 13 was cognitively intact. 5. During an interview on 1/09/25 at 3:42 p.m., Resident 43 indicated the nursing staff had "attitudes" when they talk with her and that they don't like to help her in her wheelchair. The clinical record for Resident 43 was reviewed on 1/13/25 at 10:15 a.m. The Quarterly MDS assessment, dated 11/26/24, indicated Resident 43 was cognitively intact. 6. During an interview with Resident 37 on 1/10/25 at 11:40 a.m., she indicated at times, if she hits her call light the staff will come in turn off the call light and walk out of the room. They do not return to provide the service she had requested. The clinical record for Resident 37 was reviewed on 1/13/25 at 10:20 a.m. The Annual MDS assessment, dated 11/11/24, indicated Resident 37 had moderate cognitive impairment.			

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	An interview was conducted with the Director of Nursing on 1/15/24 at 2:47 p.m. She indicated she has been working with staff on providing good customer service. She has been conducting in-service training related to dignity and customer service since October of 2024. A resident rights policy was provided by the Executive Director on 1/14/25 at 2:37 p.m. It indicated, "...Policy...The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility...4. Respect and dignity. The resident has a right to be treated with respect and dignity, including... c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do would endanger the health or safety of the resident or other residents...5. Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to...b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident..." 3.1-3(t)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to ensure care plan meetings were conducted quarterly for 2 of 2 residents reviewed for care plan meetings (Resident 63 and Resident 95).	F 0657	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 63 and 95 were not harmed. Care plan meetings have been offered/conducted. 2. All residents have the potential	02/08/2025

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	Findings include: 1. The clinical record for Resident 63 was reviewed on 1/9/25 at 2:46 p.m. The diagnosis included, but were not limited to, depression and hypertension. An Annual Minimum Data Set (MDS) assessment, completed 10/25/24, indicated he was cognitively intact. The clinical record contained a Multidisciplinary Care Conference Summary, dated 2/26/23. A Social Services Assessment, dated 11/19/24, indicated that Resident 63 was invited to his scheduled care plan meeting. During an interview on 1/9/25 at 2:46 p.m., Resident 63 indicated that he was unsure of the last time he was invited to a care plan meeting, it may have been over a year ago. During an interview on 01/14/25 at 10:42 a.m., the Social Service Director (SSD) indicated a care plan meeting was held on 2/14/24 and 11/19/24. There were no other care plan meetings held between 2/14/24 and 11/19/24. 2. The clinical record for Resident 95 was reviewed on 01/10/25 12:45 p.m. The diagnoses included, but were not limited to, hypertension, cocaine abuse, hemiplegia and hemiparesis following a cerebral infarction, and diabetes. A Quarterly Minimum Data Set assessment, completed 10/09/24, indicated she was cognitively intact. During an interview on 01/09/25 at 10:53 a.m., Resident 95 indicated she did not know what a care plan meeting was, and she had not been		to be affected. A facility-wide care plan audit will be completed and meetings offered/scheduled for those residents in need on one. 3. The Care Planning- Resident Participation policy was reviewed and no changes were indicated. Social Services staff have been re-educated on this policy. The Social Services Director or his designee will audit 10 residents per month for three months and until 100% compliance is achieved, then 10 per quarter and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	invited to one since she had been at the facility. Records regarding Resident 95's care plan meetings were provided by the Director of Nursing (DON) on 01/14/25 at 9:07 a.m. Records included a multidisciplinary care conference summary dated 04/02/2024, a social services assessment dated 10/09/24, and a progress note, dated 01/13/25, indicating a care plan invitation had been extended to Resident 95's daughter. During an interview on 01/14/25 at 10:42 a.m., the SSD indicated care plan meetings were supposed to occur quarterly. They have not occurred timely due to excess workload in the facility. On 01/10/25 at 2:00 p.m., the Executive Director provided a Care Planning-Resident Participation Policy, date implemented 11/01/2023. It indicated, " ...This facility supports the resident's right to be informed of, participate in, his or her care planning and treatment (implementation of care) ... 10. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative ..." 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to provide routine oral care and appropriate incontinence care timely to 1	F 0677	The facility will ensure this requirement is met through the following corrective measures: 1. Resident B was not harmed	02/08/2025

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	of 5 residents reviewed for Activities of Daily Living (ADL) care (Resident B). Findings include: The clinical record for Resident B was reviewed on 01/10/25 at 1:35 p.m. The diagnoses included, but were not limited to, hemiplegia (a condition causing paralysis or weakness on one side of the body) secondary to a CVA (cerebral vascular accident). A Quarterly Minimum Data Set (MDS) assessment, completed 10/25/24, indicated he was cognitively intact, had impairment on one side of the upper extremity, required supervision or touching assistance from staff with oral care, and required substantial/maximal assistance with toileting hygiene. A care plan, created on 02/06/24, indicated Resident B had a problem with oral health related to carious (decayed), and missing teeth. The goal was his oral health will not decline. The interventions, created on 02/06/24, were to assist him with oral care two times a day with a.m. and p.m. care. He was to receive his medications as ordered. He would report oral pain, bleeding gums, red inflamed tongue, white patches in oral cavity, or change in his ability to chew food. He would be referred to the dentist as needed. A care plan, created on 02/06/24, indicated Resident B was incontinent of bowel and bladder at times related to functional incontinence, decreased mental awareness, mobility, and personal unwillingness. The goal was for his functional incontinence to be managed through the care plan as evidenced by Resident B would continue to have continent episodes. The		and necessary care was provided when notified. 2. All residents who are not independent with toileting and oral care are at risk of being affected. When notified, rounds were made to ensure resident's needs were met. 3. The Peri Care policy and the Oral Care policy were reviewed and no changes were indicated. Nursing staff will be re-educated on these policies and skill"s check-off's completed. The DCS (Director of Clinical Services) or her designee check 10 residents weekly to ensure oral care is being completed for 6 weeks and until 100% compliance is achieved, then 10 times per month for 3 months and until 100% compliance is maintained. The DCS or her designee will observe toileting/peri-care on 10 random residents per week for 6 weeks and until 100% compliance is achieved, then 10 per months for 3 months and until 100% compliance is maintained and peri-care is completed per policy. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	interventions, created on 02/06/24, were to assist resident with clothing adjustment, cleansing, and transfers during toileting. The staff would encourage/remind resident to wear his incontinence products for management of his incontinence. Staff would assist resident with incontinence care and apply barrier cream as needed. During an interview on 01/09/25 at 9:47 a.m., Resident B indicated the staff do not help brush his teeth. On 01/09/25 at 9:58 a.m., Resident B indicated one of the aides told him to have a bowel movement in his brief in the bed because she didn't want to get him up. During an interview on 01/13/25 at 9:41 a.m., Resident B indicated staff did not help brush his teeth when they had provided a.m. care that morning or the morning before. Visible white debris was observed on the resident's lower teeth. Resident B indicated he put his call light on last night, and nobody came. My brief wasn't changed until this morning before breakfast. On 01/13/25 at 11:20 a.m., Resident B indicated his brief had not been changed since that morning before breakfast, record review of the task administration record indicated the last time Resident B had been toileted was on 1/13/2025 at 6:56 a.m. On 01/13/25 at 11:23 a.m., Certified Nurse Aide (CNA) 2 was observed providing incontinent care for Resident B. Resident B was wheeled into his shared bathroom by CNA 2. Hand hygiene was performed, and gloves were donned. CNA 2 assisted Resident B to stand (by holding onto back of waistband), pivot, and sit gently onto the toilet. His brief was removed and was visibly			

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	heavily saturated with urine. CNA 2 used a wet wash rag and soap to wipe the resident's perineal area and then applied barrier cream. Significant moisture was present on scrotum. Licensed Practical Nurse (LPN) 4 was present to assess a moisture associated skin damage wound on the coccyx. CNA 2 and LPN 4 assisted Resident B to stand from toilet and moisture was observed dripping from Resident B's scrotum onto the floor. A new brief was applied without the cleansing of or drying of the resident's genitalia. During an interview on 01/13/25 at 2:05 p.m., CNA 2 indicated the process for providing perineal care was to pull foreskin of the penis back and clean around it, and to use wipes or a wash rag when a resident has a bowel movement. During an interview on 01/13/25 at 2:10 p.m., CNA 3 indicated the residents get changed every two hours. On 01/14/25 at 10:26 a.m., Resident B indicated his teeth had not been brushed that morning. During an interview on 01/14/25 at 10:36 a.m., CNA 2 indicated she had not brushed Resident B's teeth, and that night shift should have done it because he was a "get-up". Night shift was supposed to get them up and prepare them for the day every morning. During an interview with the Director of Nursing (DON) on 01/14/25 at 3:01 p.m., she indicated residents should receive oral care assistance in the mornings if needed. She also indicated staff should be checking every two hours to see if incontinent residents are wet or need changed. A perineal care policy was provided by the DON			

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	on 01/13/25 at 3:49 p.m. It indicated, " ...12. Males ... g. Cleanse the shaft of the penis, using downward strokes toward the scrotum ... h. cleanse the scrotum, using a clean portion of the washcloth, new washcloth or new disposable wipe with each stroke ... i. pat dry ..." On 1/14/25 at 3:28 p.m., the DON provided the Personal Hygiene Policy, last revised 6/2021, which read " ...1. Personal hygiene will be performed 2 times daily in the morning and before bed ... 4. Personal hygiene may include, but is not limited to... a. Oral care ..." This citation relates to Complaint IN00446265. 3.1-38(a)(3)(A) 3.1-38(a)(3)(C)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to provide a resident with adequate assistance of two staff members for bed mobility during perineal care resulting in a fall from bed, and ensure a transfer from the wheelchair to the toilet was performed in accordance with the plan of care for 2 of 4 residents reviewed for accidents and 1 of 5 residents reviewed for Activities of Daily Living (ADLs). This deficient practice resulted in Resident 60 falling and sustaining a fracture of the left upper arm. (Resident 1, Resident 60, and Resident B) Findings include: 1a. The clinical record for Resident 60 was	F 0689	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 1 was not harmed. Staff was provided with re-education following the fall. Resident 60 was not harmed. Staff was re-educated when notified on gait belt use. Resident B continues to heal. She has received care necessary related to her fracture. 2. All residents requiring assistance with transfers have the potential to be affected. 3. The Gait Belt policy was reviewed and no changes were indicated. Nursing staff will be	02/08/2025

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	reviewed on 1/9/25 at 9:55 a.m. The diagnoses included, but were not limited to, bone density disorder, abnormalities of gait and mobility, muscle weakness, difficulty in walking, and stroke with hemiplegia (paralysis one side of body) affecting left non-dominant side. The Annual Minimum Data Set (MDS) assessment, dated 8/7/24, indicated Resident 60 was cognitively intact. The resident had impairment on upper and lower of one side of the body. The resident's functional status of toilet transfers and sit-to-stand function was substantial maximal assistance. The caregiver does more than half of the assistance. The Quarterly MDS assessment, dated 11/4/24, indicated the resident was cognitively intact. The resident's functional status of toilet transfers was dependent. The caregiver does all the effort. A fall care plan, date initiated 2/1/19, indicated, "I am at risk for falls related to Lt. [left] sided hemiparesis, history of falls...Goal. My care plan interventions will minimize my risk for falls resulting serious injury..." An ADLs care plan, dated 6/25/24, indicated, "I need assistance with my ADLS; bed mobility, eating, toileting, transferring, dressing and grooming and bathing, related to activity intolerance, muscle weakness, lack of coordination, left side hemiplegia/hemiparesis..." The resident's interventions included, but were not limited to, gait belt utilized with transfers, date initiated of 5/1/24, and assistance with transfers utilizing two staff members initiation date of 8/2/21. A care plan, dated 6/25/24, indicated, "I am at risk		educated on this policy and on the use of Point of Care to identify the appropriate number of staff needed for transfers and bed mobility. The DON or her designee will observe 10 transfers/toileting/bed mobility for 10 residents per week for 6 weeks and until 100% compliance is achieved to ensure gait belts and appropriate number of staff are utilized, then 10 residents per month for three months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	for pathological fractures d/t [due to] dx [diagnosis] of osteopenia [bone density is lower than normal/bone loss]". A progress note, dated 10/10/24 at 11:15 a.m., indicated Resident 60 had fallen. "Description of fall: Seen resident accompanied by Physical Therapist [PT] in the bathroom, Per PT, they were transferring resident from toilet to her wheelchair when she lost her balance and fell hit her head in the door [sic]. Per resident she lost her balance and hit her head in the door. Range of motion; mental status, neurochecks if unwitnessed or hit head; injuries: witnessed fall, ROM [range of motion] wnl [within normal limits], swelling on forehead noted, Per resident she lost her balance and fell hit her head in the door [sic]. Immediate intervention: Assisted back resident to her chair, vital signs and neuro [neurological] checks initiated, noted to have swelling on resident forehead, ice pack applied over forehead. Physician notification... informed and recommend having CT [medical image scan] head for the resident since she was on blood thinner [sic]...." A nursing note, dated 10/10/24 at 8:27 p.m., indicated, "Res. [Resident 60] returned from hospital visit r/t [related to] fall with head contusion [bruise]. CT of head & spine with no findings, no new orders received. Res. alert & orientated x3 [times 3], extensive assist x 2 [two] to bed...Will continue to observe with 3 [three] day follow up fall observation." An Interdisciplinary Team fall note, dated 10/11/24 at 9:25 a.m., indicated "...Summary of the fall: Patient [Resident 60] lost footing during the fall. Root cause of fall: Patient lost footing while being transferred to toilet. Intervention and care plan updated: OT [Occupational Therapy] to evaluate			

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	and treat for transfers to/from toilet." An Occupational Therapy evaluation, dated 10/11/24 at 12:56 p.m., indicated "...Patient [Resident 60] demonstrates decreased strength and indep [independence] with toilet transfer. Recommend 2 [two] person assist with gait belt and one step cues for proper foot placement...Pt [patient] had a fall on 10/10 during transfer off toilet..." A nursing note, dated 10/20/24 at 2:00 p.m., indicated, "Resident was transferring from w/c [wheelchair] to toilet, her foot was buckled and staff had to put resident down on floor. Fall was witnessed, resident didn't touch the floor. VS [vital signs] WNL [within normal limits], no injuries noted after fall..." A nursing note, dated 10/21/24 at 7:31 a.m., indicated, "...Resident seen in bed, complain of left shoulder pain, swelling noted...[medical provider] informed with order for Left shoulder X-ray requested." A radiology report for Resident 60, dated 10/21/24 at 9:25 a.m., indicated, "...Findings: There is an acute fracture proximal left humerus. There is mild displacement..." A nursing note, dated 10/21/24 at 11:20 a.m., indicated, "Left Shoulder x-ray: Conclusion: Acute Fracture Proximal left humerus. [name of medical providers] informed and order to send resident to ER [emergency room]..." A "Facility Reported Incident [FRI]" was reported to the Indiana Department of Health, dated 10/21/24, indicated an incident had occurred, on 10/20/24, with Resident 60. The resident's knees			

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	gave out during a transfer from wheelchair to toilet resulting with an acute fracture and displacement of the proximal humerous. The follow up on the report indicated, "Resident returned from the ER [emergency room] with orders to follow up with orthopedics for treatment...Resident pain assessed every shift and scheduled and PRN [as needed] pain medications administered as ordered. Resident was previously noted as requiring assistance of two for transfers. An IDT review of the resident's fall history and mobility determined that the resident is unable to safely transfer to the toilet with an assist of two. As a result, a new intervention was put in place for toileting with a bedpan and assistance of two for bed mobility, along with the use of a hoyer lift [mechanical lift] for transfers..." A care plan, dated 10/22/24, indicated, "I have a traumatic fracture/pathological fracture of the left proximal humerus [the top portion of the upper arm bone]..." The investigation into Resident 60's fall was provided by the Director of Nursing (DON), on 1/15/25 at 10:55 a.m., and included, but was not limited to, the following: A written statement by Certified Nurse Aide (CNA) 1, dated 10/20/24, indicated, "I [CNA 1] went to take [Resident 60] to bathroom. She had stated she was ok [okay] to stand she stood...but her foot gave out as she was standing she fell on my leg. I made sure she was off my foot after she fell on my foot and went to get nurse. She was already complaining about pain on her left arm when we was [sic] getting her up for morning care we let nurse know she was complaining asap." A staff education form for CNA 1, dated 10/21/24,			

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	indicated "...Safe transfers. This includes the following areas: 1. Area for Improvement: a) following resident plan of care. b) using a gait belt with all transfers...2. Necessary Steps for Improvement: a) Use the Kardex located in [electronic medical chart] dashboard to find resident transfer/care information. b) Get report from the Charge nurse to stay informed of resident changes..." Hospital records, date of arrival on 10/21/24, and discharged on 10/21/24, indicated "...[Resident 60] presenting today with concerns of left arm pain and a fall. Report from EMS [Emergency Medical Services] which he received from the facility states that they were attempting to move patient in bed when they pulled on her left arm. X-ray at facility confirmed she had a broken humerus. However patient tells me that she fell in the bathroom either today or a few days ago on the wet tile. She reports since then her arm has been hurting. Patient arrives with left arm pain...She has some bruises that appear to be in late stages of healing on her face so we will obtain basic CT head and neck imaging as well. Admission was considered so further work-up was obtained. Please refer to ED [emergency department] course for additional details on this work-up...Workup here notable for a mildly displaced fracture through the proximal neck of the left humerus. Patient was placed in a sling here and referred to orthopedic for further observation. Basic labs with no emergent abnormalities...At this point I do think she is safe and stable for discharge at this time. We need to follow-up closely with orthopedics...Clinical Impression 1. Fall, initial encounter 2. Other closed nondisplaced fracture of proximal end of left humerus..." An interview was conducted with the Therapy			

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	Director on 1/15/25 at 11:41 a.m. She indicated the staff should be utilizing gait belts while transferring residents. Resident 60 did have a fall with a PT in the bathroom on 10/10/24. After that fall, the resident's ability to safely transfer was evaluated. It was determined Resident 60 was a two person assist with transfers. After the resident's fall with the nursing staff on 10/20/24; the resident was evaluated. Resident 60 transfers now utilizing a mechanical lift due to her decline and unable to safely transfer. During an interview on 1/15/25 at 12:47 p.m., Resident 60 indicated she fell in the bathroom when a CNA was transferring her to the toilet. There was only one staff person assisting her with the transfer, and the resident was not wearing a gait belt. Resident 60 had lost her balance and fell. The CNA called for help, and a nurse came into the bathroom to assist. During that time, the nurse had pulled on her left arm to help the CNA get her up. The fall resulted with a broken left arm. She was sent to the hospital. She did not have to have surgery, but she did have to be seen by an orthopedic specialist for a while. An interview was conducted with CNA 1 on 1/15/25 at 1/15/25. She indicated she was transferring Resident 60 when she had fallen while transferring her to the toilet. During that time, CNA 1 was the only staff person conducting the transfer. She had utilized the back of the resident's pants to assist with the transfer. The resident's leg gave out, and Resident 60 fell on CNA 1's leg and her foot. The resident did not fall on the floor. After, CNA 1 had called for the nurse, and she came into the bathroom to assist with the removal of the resident off CNA 1's foot and leg. The nurse had placed her arms underneath the resident's arm to assist the resident to stand up.			

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	CNA 1 had not worked with Resident 60 prior to that day. She did receive report by staff prior to working on the hallway, but she was not told the resident was a two person assist with transfers until after the resident had fallen. She would have never transferred Resident 60 without assistance of another staff person if she had known. 1b. The clinical record for Resident B was reviewed on 01/10/25 at 1:35 p.m. The diagnoses included, but were not limited to, hemiplegia (a condition causing paralysis or weakness on one side of the body) secondary to a CVA (cerebral vascular accident). A random observation of Resident B being transferred from his wheelchair to the toilet was made with CNA 2 and the Wound Nurse on 1/13/25 at 11:23 a.m. During the observation, a gait belt was not utilized during the transfer. Resident B indicated at that time; he was not having a good day with transferring. An interview was conducted with the DON on 1/15/25 at 3:25 p.m. She indicated the nursing staff were to utilize gait belts when transferring residents. A "Use of Gait Belt" policy was provided by the DON, on 1/15/25 at 10:55 a.m., and it indicated the following, "...Policy: It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety...Compliance Guidelines: 1. Each nursing department employee will be given a gait belt during orientation. 2. All employees will receive education on the proper use of gait belt during orientation and annually. 3. It will be the responsibility of each employee to ensure they have it available for use at all times when at work.			

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	4. Any and all repairs needed or issues with gait belt will be reported to the supervisor immediately for replacement. 5. Failure to use gait belt properly may result in termination." The Indiana State Department of Health Nurse Aide Curriculum, revised November 19, 2015, indicated the following, "...PROCEDURE #24: USING A GAIT BELT TO ASSIST WITH AMBULATION...3. Place belt around resident's waist with the buckle in front and adjust to a snug fit ensuring that you can get your hands under the belt...4. Assist the resident to stand on count of three...6. Stand to side and slightly behind resident while continuing to hold onto belt...PROCEDURE #26: TRANSFER TO WHEELCHAIR...2. Place wheelchair on resident's unaffected side...4. Stand in front of resident and apply gait belt around the resident's abdomen...."2. The clinical record for Resident 1 was reviewed on 1/8/25 at 3:01 p.m. The diagnoses included, but were not limited to, cerebral palsy and aphasia (inability to speak). A care plan, last revised on 7/1/24, indicated he required total assistance with activities of daily living due to his diagnosis of cerebral palsy. The goal was for him to allow staff to render needed care daily. The interventions included, but were not limited to, total assist of two staff members for bed mobility. A care plan, last revised on 6/19/23, indicated he was at risk for falls related to cerebral palsy and total assistance with all transfers. The goal was the care plan interventions would minimize the risk to no serious injuries. The interventions included, but were not limited to, place in the center of the bed for positioning.			

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	A Quarterly MDS assessment, completed 11/10/24, indicated he rarely/never made himself understood. He was dependent on staff for bed mobility and toilet hygiene. A progress note, dated 12/10/24 at 6:43 p.m., indicated Resident 1 had a witnessed fall. The CNA was turning Resident 1 while changing him when he slipped from the bed. There was no change in his assisted range of motion, no pain with passive range of motion, neurological checks were initiated, and there was no change in his mental status or consciousness. A Fall Interdisciplinary Team Note, dated 12/11/24 at 9:49 a.m., indicated the summary of the fall was Resident 1 slid from the bed when turned by the CNA to provide perineal care. The root cause of the fall was one person assisting with perineal care. The interventions and care plan update included the staff were educated on providing care. During an interview on 1/14/25 at 3:30 p.m., the Director of Nursing indicated the CNA was changing Resident 1, who had a low air loss mattress. He got too close to the side of the mattress and just slid out. There should have been two staff members providing care. On 1/15/25 at 10:15 a.m., the Director of Nursing provided the Fall Investigation and Risk Evaluation, last revised June 2022, which read "...It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assisted devices to prevent avoidable accidents...The residents will have a care plan developed that includes the resident's complications and risks, an attainable and			

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	measurable goal, and individualized interventions to decrease their risk of falls...'Avoidable Accident' means that an accident occurred because the facility failed to...Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of and accident...Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice...'Supervision/Adequate Supervision' refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment...." 3.1-45(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on interview and record review, the facility failed to ensure pre and post assessments were conducted for a resident receiving dialysis for 1 of 1 resident reviewed for dialysis. (Resident 43) Findings include: The clinical record for Resident 43 was reviewed on 1/9/25 at 1:55 p.m. The diagnoses included, but	F 0698	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 43 was not affected. 2. Any resident receiving dialysis services has the potential to be affected. Resident 43 is currently the only resident meeting that criteria. 3. The Dialysis policy was	02/08/2025

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	were not limited to, end stage renal disease. A dialysis care plan, dated 10/25/24, indicated "I [Resident 43] have end stage kidney disease requiring dialysis. I no longer have any urinary output. I have a fistula in my left arm". The goal was to "remain free of infection through the next review utilizing my care plan interventions". The interventions included "I will report and you will observe for side effects of dialysis such as change in level of consciousness, cramping, fatigue, headaches, itching, and bleeding..." A physician order, dated 12/31/21, indicated the resident received dialysis Mondays, Wednesdays, and Fridays at 10:30 a.m. The November 2024, December 2024, and January 2025 pre and post dialysis assessments for Resident 43 were reviewed. The following day(s) indicated the pre and/or post dialysis assessments were not located in the clinical record: 11/20/24 - pre dialysis assessment, 11/24/24 - post dialysis assessment, 11/26/24 - post dialysis assessment, 12/6/24 - pre dialysis assessment, 12/11/24 - post dialysis assessment, 12/16/24 - post dialysis assessment, and 1/13/25 - post dialysis assessment. An interview was conducted with the Director of Nursing (DON) on 1/14/25 at 2:57 p.m. She indicated she was unable to locate the missing pre and post dialysis assessments for Resident 43 in November 2024, December 2024, and January of 2025. The staff should be doing pre and post dialysis assessments for residents' receiving dialysis.		reviewed and no changes were indicated. Licensed nursing staff will be re-educated on this policy. The DON or her designee will audit 3 times weekly to ensure post-dialysis assessments are completed for 6 weeks and until 100% compliance is achieved, then weekly for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	A dialysis policy was provided by the DON on 1/14/25 at 2:00 p.m. It indicated, "...Policy: It is the desire of this facility to provide appropriate care for end stage renal disease (ERSD) residents receiving dialysis. Staff caring for residents receiving dialysis outside the facility will be trained and educated in the special needs of these residents... Residents receiving hemodialysis will receive appropriate monitoring and care from the facility and the dialysis provider in order to coordinate care. To set appropriate guidelines for monitoring the health and safety of residents receiving dialysis care...Pre and Post Dialysis: 1. A [name of corporation] pre-dialysis assessment will be completed before dialysis. This includes... a. level of consciousness, b. vital signs, c. breath sounds, d. skin, vascular access, f. edema, g. signs and symptoms of infection, h. Complaints such as chest pain, shortness of breath, cough, i. Assess resident for nausea, vomiting, constipation, diarrhea, abdominal pain, itching, bleeding, change in urine output amount or appearance, or falls. Any abnormalities will be communicated by the charge nurse to the dialysis center. The facility will communicate any prn [as needed] medications given before dialysis. 2. A [name of corporation] post dialysis form will be completed after dialysis and compared to the pre-assessment. Any abnormal assessment findings will be reported to the physician or NP [Nurse Practitioner] ...." 3.1-37(a)			