STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00423953, IN00424859, and IN00425475. Complaint IN00423953 - No deficiencies related to the allegations are cited. Complaint IN00424859 - State deficiency related to the allegations is cited at R052. Complaint IN00425475 - No deficiencies related to the allegations are cited. Survey dates: February 27 and 28, 2024 Facility number: 013069 Residential Census: 107 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/1/24.	R 0000	Residences at Deer 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 hereby 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 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.	

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on record review and interview, the facility failed to ensure the resident's Responsible Party and/or Physician were notified timely after a fall, for 1 of 10 records reviewed. (Resident B) Finding includes: The record for Resident B was reviewed on 2/27/24 at 2:00 p.m. Diagnoses included, but were not limited to, memory impairment, hearing impairment, and dementia. A Pre Admission Assessment, dated 10/10/23, indicated the resident's mental status was identified as mild confusion. A 10/30/23 Service Plan, indicated the resident had moderate impairment and required cues to plan and organize. Nurses' Notes, dated 1/31/24 at 7:30 a.m., indicated the resident was found on the floor and his wheelchair was next to him. The resident stated, "I tried to get up and use the bathroom." The resident had some pain to the left hip, but showed no signs or symptoms of any injuries. Nurses' Notes, dated 2/27/24 at 11:31 a.m., indicated the NP and the family were notified of the fall on 1/31/24. There was no documentation the resident's Physician or family were notified of the fall on 1/31/24 prior to 2/27/24. During an interview on 2/28/24 at 1:10 p.m., the Director of Nursing indicated the Physician,	R 0036	Resident B (Resident #2) - had no injury related to the fall. The responsible and the physician for Resident B (Resident #2) were notified of the fall on 2/27/2024. An audit was completed of all other residents who had recent falls to ensure notification to the responsible party and physician was made. No other residents were lacking notifications. The licensed nurse will continue to be responsible for ensuring documentation in the clinical record is complete and accurate. The Director of Nursing/Designee will conduct in-services with nursing staff regarding timely notification of Physician and Family. Director of Nursing or Designee will review daily charting to ensure that notification of Physician and Family is completed in timely manner 5 days per week for the next 90 days or until 100% compliance is achieved.	03/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
	responsible party and/or family member were to be notified in a timely manner after a fall. The current 1/1/13 "Change of Condition" policy, provided by the Director of Nursing on 2/28/24 at 2:15 p.m., indicated when a resident's significant change was identified, the family/responsible party will be notified as soon as possible but at least within 24 hours of the change. The Physician will be notified as soon as possible but at least 24 hours within the significant change.			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on record review and interview, the facility failed to ensure a resident was free from neglect, related to adequate supervision not provided for a resident with dementia, who had a history of exit seeking behaviors. The resident exited from the building without the knowledge of the staff working in the facility, was found by the local police department, and was taken to the hospital Emergency Room, for 1 of 3 residents reviewed for facility reported incidents. (Resident B) Finding includes: The record for Resident B was reviewed on 2/27/24 at 2:00 p.m. Diagnoses included, but were not limited to, memory impairment, hearing impairment, and dementia. A Pre admission assessment, dated 10/10/23, indicated the resident's mental status was identified as mild confusion. A 10/30/23 Service Plan, indicated the resident had moderate impairment and required cues to plan and organize.	R 0052	Resident B (Resident #2) was assed upon return to the facility. No injuries were observed. There New residents are assessed and those with mild confusion such as resident B are considered appropriate for Assisted Living. Residents are able to ambulate throughout the community without time constraints. As this resident's cognition began to decline the facility did appropriately contact family and physician in reference to a transfer to memory support. The facility was actively transferring this resident to memory care after obtaining the consent of the family when the resident elected to exit the facility while the resident's belongings were being relocated. The outdoor temperature was fifty degrees, the resident was appropriately dressed and the time stamp from surveillance cameras	03/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
	A Nurses' Note, dated 11/9/23 at 5:31 a.m., indicated the resident was observed with urine soaked pajamas and told the nurse he was wandering around the place looking for his wife. The resident was unable to locate his apartment and had to be escorted back to his apartment. A Nurses' Note, dated 12/23/23 at 2:19 a.m., indicated at 1:45 a.m. the resident was observed walking towards the nursing station looking disoriented, with minimal verbal response. The resident was escorted back to his apartment. Ten minutes later, the resident returned to the nursing station with his cane, and was told to go back to his room and get some rest. The resident did not go back to his room, instead he took the elevator down to the first floor, and was observed heading towards the back exit. The resident was redirected by staff, and brought back up to his apartment. The resident was an elopement risk. Nurses' Notes, dated 12/23/23 at 4:31 p.m., indicated the resident was observed wandering the assisted living looking for the main dining room. At that time, the resident was escorted to the dining room with staff, and was told when he was ready to return, to tell someone as he required direction to his apartment. The resident required verbal cueing and escorts with staff to maneuver through the building and to find his apartment. He was found in another apartment eating her snacks on the kitchen table, and the resident who lived there told him to leave. Nurses' Notes, dated 12/25/23 at 12:43 p.m., indicated the resident had to be escorted to meals, as he was not able to find the dining room. The resident would get in the elevator, go to the 1st floor and wander the first floor, he would then		and notification to police was twenty minutes. He was not admitted to the hospital and was in good health when he was escorted back to the facility from the hospital by our staff. He is doing well and adjusting nicely to memory support. All residents in assisted living were assessed for cognitive awareness. As a result of these assessments, all residents were verified as appropriate for assisted living at that time. On an ongoing basis, all residents will be assessed upon admission, semi-annually thereafter and upon a change in condition. Residents who are assessed for memory care will be transferred immediately upon receiving consent from the responsible party. Director of Nursing will review nurses notes for all assisted living residents 5 days per week for the next 90 days to assure ongoing compliance or until 100% compliance is achieved. Staff will be re-inserviced on responsible party notifications.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
	return to the 3rd floor and inform staff that he was hungry. Staff then had to walk him to dining room, seat him, and ask him to wait for the food. Nurses' Notes, dated 12/26/23 at 6:13 a.m., indicated the resident was observed exit seeking throughout the night shift. The resident appeared to be confused, and was unable to explain his whereabouts. He continued to leave the unit by the elevator that was located next to his room, and wandered around the first floor. The resident required constant redirection and monitoring. Nurses' Notes, dated 12/26/23 at 9:40 a.m., indicated the resident's responsible party was notified of the increased confusion and most recent behaviors. It was decided the resident would move into the memory support unit as soon as possible. Nurses' Notes, dated 12/26/23 at 11:35 a.m., indicated the resident was observed exit seeking by a staff member, and attempts to redirect were unsuccessful. Nursing was notified by a staff member of the exit seeking, and an immediate search began, with all staff checking all units and the building inside and outside. Staff were unable to locate the resident, so the local police department were notified. The local police arrived and indicated the resident was found wandering in the adjacent neighborhood with no visible injuries, and was taken to the hospital emergency room. Nurses' Notes, dated 12/26/23 at 12:48 p.m., indicated the resident returned back to the facility and a complete physical assessment was completed. A wanderguard was applied to his right wrist.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
	A Nurses' Note, dated 12/26/23 at 4:48 p.m., indicated "spoke with night nurse to clarify events of previous night. Staff observed [name of resident] with episodes of confusion, wandering around 3rd floor. Staff observed [name of resident] getting on elevator so staff followed him downstairs and observed him wandering around main floor walking toward back entrance. Staff was able to redirect him and get him back to 3rd floor..." A Police Report, dated 12/26/23 at 10:16 a.m., indicated the resident was found walking down the middle of the road down from a gas station. The EMT's were called and took him to the hospital. The facility's investigation indicated many staff members were interviewed. The beautician's interview indicated she had seen the resident between 9:20 a.m., and 9:35 a.m., looking into the salon window. She did not recognize the person. Later on, when a CNA came to pick up the client she had just served, she told her they were looking for a male resident and gave his name. She told the CNA he might have walked out the back entrance by the salon. The midnight nurse's interview, indicated the resident was exit seeking all night, would get on the elevator and go to the first floor, so they followed him downstairs. The resident did not touch the door to go out, never attempted to open the doors downstairs, but was easily directed A security camera image, time stamped at 9:47 a.m., indicated the resident was standing in front of the exit door by employee lockers. A security camera image, time stamped at 9:49			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
	a.m., indicated the resident was observed standing outside of the building in the parking lot on the side of the building. During an interview on 2/28/24 at 11:35 a.m., the Administrator indicated they were not in the process of moving the resident to the memory support unit when he eloped. They had just notified the responsible party and the NP of the need to move him to the locked unit. During an interview on 2/28/24 at 12:00 p.m., the Director of Nursing indicated she had already put a plan in place for any resident who showed signs of increased confusion and exit seeking, they will go to the memory support unit right away. This citation relates to Complaint IN00424859.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure the required personnel annual inservices, which include Dementia, were completed, for 4 of 6 staff members reviewed. (LPN 1, LPN 2, RN 1 and the Concierge) Findings include: The annual inservice records were reviewed on 2/27/24 at 1:05 p.m. 1. LPN 1 was hired 12/27/17 and had completed zero hours of the required 3 hours of annual dementia training.. 2. LPN 2 was hired on 8/15/15 and had completed zero hours of the required 3 hours of annual dementia training.	R 0120	No residents were affected by this citation. LPN1-Dementia training completed. LPN2- Dementia training completed. RN1-No longer employed at facility. Concierge-Dementia training completed. The Business Office Director/designee will audit all other employee files and those found missing the required dementia education will have it repeated and documented in their file. The Business Office Director will continue to monitor for	03/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
	3. RN 1 was hired on 7/20/21 and had completed zero hours of the required 3 hours of annual dementia training. 4. The Concierge was hired on 10/27/20 and had completed zero hours of the required 3 hours of annual dementia training During an interview on 2/28/24 at 12:00 p.m., the Director of Nursing indicated there was no annual dementia training completed for any of the above staff.		compliance for 3 months or until 100% compliance is achieved.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on record review and interview, the facility failed to ensure new employees had a job specific orientation for 2 of 5 new employee files reviewed. (Housekeeper 1 and Dishwasher 1) Findings include: The employee files were reviewed on 2/28/23 at 1:13 p.m. a. Housekeeper 1 was hired on 2/16/24 and signed a job specific orientation for a CNA. b. Dishwasher 1 was hired on 2/16/24 and signed a job specific orientation for a CNA. During an interview on 2/28/24 at 1:40 p.m., the Business Office Manager indicated there was no job specific orientation provided to new hires. They typically go over the CNA job description with all hires.	R 0123	No residents were affected by this citation. Housekeeper 1- Job specific orientation and check list completed. Dishwasher 1-Job specific orientation and check list completed. The Business Office Director/designee will audit all other employee files and those found missing the required job specific orientation and checklist will have it repeated and documented in their file. The Business Office Director will continue to monitor for compliance for 3 months or until 100% compliance is achieved.	03/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented, related to monitoring bruises, completing follow up documentation after a fall, and documenting neurological checks, for 4 of 10 sampled residents. (Residents 9, 10, 3, and 4) Findings include: 1. The record for Resident 9 was reviewed on 2/28/24 at 9:06 a.m. Diagnoses included, but were not limited to, Alzheimer's disease without behavior disturbance, hypertension, and anemia. A Nurses' Note, dated 7/15/23 at 12:26 p.m., indicated the resident was observed with a 0.5 centimeter (cm) x 0.5 cm round purplish discoloration to the top of her left hand. A message was left with the Physician's office requesting the resident to be seen on 7/18/23. A Nurses' Note, dated 7/16/23 at 8:35 p.m., indicated the 0.5 cm x 0.5 cm purplish discoloration remained to the top of the left hand. The next entry in the Nurses' Notes related to the discoloration was on 7/18/23 at 12:33 p.m. The entry indicated the resident was seen by the Nurse Practitioner (NP), who observed the bruising with no new orders. A Nurses' Note, dated 7/28/23 at 1:52 p.m., indicated the bruising to the top of the resident's left hand had healed. There was no documentation between 7/19 and 7/27/23 regarding the bruising.	R 0349	Resident 9-Full body assessment completed after the survey and no new bruises or new falls noted. Resident 10-Full body assessment completed after the survey and no new bruises or new falls were noted. Resident 3-Full body assessment completed after the survey and no new bruises or new falls were noted. Resident-4 Full body assessment completed after the survey and no new bruises or new falls were noted. The Director of Nursing reviewed all records of residents to identify any that had a new bruise or a new fall to ensure complete and accurate documentation is in the medical record for nurse monitoring. The Director of Nursing will re-inservice licensed nurses on complete and accurate documentation in the clinical record. Director of nursing or designee will review fall charting daily, 5 days per week for the next 90 days or until 100% compliance is achieved to ensure that documentation is complete and accurate.	03/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
	During an interview on 2/28/24 at 2:30 p.m., the Director of Nursing (DON) indicated she would have expected documentation to be completed at least daily until the bruising was resolved. 2. The record for Resident 10 was reviewed on 2/27/24 at 3:05 p.m. Diagnoses included, but were not limited to dementia, anxiety, and repeated falls. A Nurses' Note, dated 9/25/23 at 2:10 p.m., indicated the resident had a fall in the dining room. She sustained a bruise to the right middle finger and the finger was swollen as well. The Hospice Nurse applied a splint to the finger, however, the resident kept removing it. A Nurses' Note, dated 9/26/23 at 7:23 a.m., indicated the resident's finger was still bruised. There was no more documentation or an assessment of the finger after 9/26/23. A Nurses' Note, dated 10/4/23 at 1:49 p.m., indicated the Hospice CNA observed blood from the resident's right foot. The nurse assessed the area, and noted a cut on her foot, so she cleansed it and put a bandage over the area. There was no more documentation or an assessment of the cut on the right foot. A Nurses' Note, dated 12/30/23 at 9:11 a.m., indicated the resident was observed walking down the hallway with a bloody nose and bruised left eye. The resident was unable to tell staff what had happened. Observation of the resident's room and bathroom, indicated there was blood on the carpet, on the bathroom floor, toilet paper holder and the wall in the bathroom.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
	There was no documentation of an ongoing neurological assessment of the resident for at least 72 hours after a suspected fall and hitting her head. A Nurses' Note, dated 2/27/24 at 2:22 a.m., indicated staff found the resident on the bathroom floor in a sitting position with a hematoma to the right forehead. The EMT's were notified and the resident was taken to the hospital. At 11:40 a.m., the Emergency Room Nurse indicated the resident was currently being observed for multiple brain bleeds, however, they were planning on discharging her later that evening. A Nurses' Note, dated 2/27/24 at 9:28 p.m., indicated the resident returned to facility at 4:00 p.m. The right side of her head, face, eye, ear and forehead remained bruised and reddened. There was a bump on the right side of the head. There were no new orders. The resident refused to have her vital signs checked. There was no documentation of an ongoing neurological assessment of the resident after she returned from the hospital. During an interview on 2/28/24 at 1:10 p.m., the Director of Nursing (DON) indicated nursing staff were documenting that neurological checks were completed in the progress notes, however, there was no form to prove they were being done. During an interview on 2/28/24 at 2:10 p.m., the DON indicated the facility does not have a fall policy or a neurological check policy. She indicated it was her expectation for staff to complete a neurological assessment for a resident that had an unwitnessed fall with a head injury. There was no additional follow up documentation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
	after the swollen finger or the cut on the right foot.3. During a random observation, on 2/27/24 at 12:45 p.m., Resident 3 had a bruised golf ball sized contusion to his left forehead. The record for Resident 3 was reviewed on 2/27/24 at 12:20 p.m. Diagnoses included, but were not limited to, chronic pain, dementia without behavior disturbance, hypertension (high blood pressure), and peripheral arterial disease (poor circulation). The Service Plan, dated 11/14/24, indicated the resident was severely impaired for daily decision making and he required assistance with dressing and hygiene. A Fall/ Incident note, dated 2/23/24 at 6:11 p.m., indicated the resident was attempting to get juice out of a refrigerator in the dining room and stumbled forward, hitting his head on the wall next to the refrigerator, causing a hematoma. The resident was laughing and stated " Boy did that hurt." Minimal bleeding. The area was cleansed and ice applied. Neuro check completed. There were no ongoing continuous neurological checks completed and documented for 72 hours after the fall. During an interview on 2/28/24 at 1:11 p.m., Director of Nursing indicated the facility does not have a form to document neurological checks. 4. During an observation on 2/28/24 at 9:48 a.m., Resident 4 was sitting in her wheelchair quietly watching television in the common room. She had a quarter sized healing scab on the back of her head . The record for Resident 4 was reviewed on 2/27/23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
	at 2:11 p.m. Diagnoses included, but were not limited to, dementia, atrial fibrillation (abnormal heart rhythm), anxiety, and depression. A Semi-Annual Assessment, dated 1/1/24, indicated the resident required physical assistance with mobility, hygiene/ dressing, and transfers. The resident was incontinent and required reminders and assistance 4 or more times a day. Cognition was moderately impaired for daily decision making and required cueing to organize day. A Nurses Note, dated 12/6/23 at 11:00 p.m., indicated the resident was found sitting on the floor behind her door. The resident reported she fell in the bathroom and scooted to the door. No injuries were noted. A Nurse's Note, dated 1/29/24 at 11:24 a.m., indicated the resident was observed lying on the kitchen floor. No injuries were noted and a neurological check was completed. A Nurse's Note, dated 2/6/24 at 3:50 a.m., indicated the resident returned from the hospital with 6 staples to a laceration on the back of her head. The resident's head was wrapped with gauze and a neurological check was completed with no concerns. A Nurses' Note, dated, 2/6/24 at 8:27 a.m., indicated the resident had 6 staples to back of her head. The site was noted to be clean, dry, and intact. A neurological check was completed and was within normal limits. The Nurse Practitioner (NP) was in to assess the resident and was made aware of staples to the resident's posterior head. A Nurses' Note, dated 2/6/24 at 6:01 p.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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
	indicated the resident had 6 staples to her posterior head with no signs and symptoms of infection. A neurological check was completed and was within normal limits. A Incident Note, dated 2/5/24, at 11:15 p.m., indicated the nurse was notified by the CNA that the resident was found on the floor in her apartment. The resident was sitting on the floor in the kitchen and there was a bleeding laceration noted to the back of her head. The resident indicated, "I fell and hit my head." Pressure was applied to the laceration and the NP was notified. The resident was sent to the hospital per NP orders. There was lack of clinical documentation that indicated neurological checks were performed after a fall with major injury on 2/5/24. A Nurses' Note, dated 2/23/24 at 2:37 p.m., indicated the CNA notified the nurse of a resident's unwitnessed fall. The Resident was found on the floor near the kitchen. No injuries noted, vital signs were obtained and a neurological check revealed no deficits. There was lack of clinical documentation that neurological checks were performed after unwitnessed falls. The unwitnessed falls occurred on 12/6/23, 1/29/24, 2/5/24, and 2/23/24. Neurological checks were being documented randomly as completed in the nurses' notes. During an interview on 2//28/24 at 1:11 p.m., the Director of Nursing (DON) indicated the facility does not have a form to document neurological checks, and she would implement that process immediately.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT DEER CREEK	401 EAST US 30 SCHERERVILLE, IN 46375

(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