STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING _____ B. WING _____	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00434201 and IN00434011 Complaint IN00434201 - Federal/State deficiencies related to the allegations are cited at F 609 Complaint IN00434011- No deficiencies related to the allegations are cited. Survey dates: July 1 and 2, 2024 Facility number: 012329 Provider number: 155784 AIM number: 201002500 Census Bed Type: SNF/NF: 91 Total: 91 Census Payor Type: Medicare: 18 Medicaid: 51 Other: 22 Total: 91 This deficiency reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 7/8/2024	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		

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

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F 609	Continued From page 1 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete and submit a timely 5-day follow-up report regarding a fall investigation that had been reported to IDOH (Indiana State Department of Health) for 1 of 3 residents reviewed for falls. (Resident D) Findings include: A record review was completed, on 7/1/2024 at 11:24 A.M. The resident's diagnoses included, but were not limited to: atrial fibrillation, metabolic encephalopathy, dementia, hypertension,	F 609	Past noncompliance: no plan of correction required.	

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F 609	Continued From page 2	F 609		

weakness and fracture of right pubis.

A Significant Change MDS (Minimum Data Set) Assessment, dated 6/13/2024, indicated Resident D was severely cognitive impaired, required the assistance of 1 staff member for transfers and utilized a front wheeled walker for mobility.

A current care plan, dated 2/15/2023, indicated the resident was at risk for falls related to: "History of recent fall with fracture to right pelvic region, age, medication use, incontinence, impaired mobility. Resident's lack of understanding of her own limitations, abnormalities of gait and mobility, unsteadiness on feet and lack of coordination."

A Nursing Progress Note, dated 6/12/2024 at 11:45 P.M., indicated Resident D was found on her bathroom floor, on her right side with her head facing the toilet. The resident had complaints of pain to her right hip, right shoulder, head and neck. She had a 5cm (centimeters) in length laceration to her left lower extremity. The Director of Nursing, Executive Director, Medical Director and resident's family member were notified and 911 was notified. A report was given to the local receiving hospital and Resident D was transferred by paramedics to the hospital.

A Progress Note, dated 6/13/2024 at 8:40 A.M., indicated Resident D had returned to facility via the local ambulance transport service.

An IDT (Interdisciplinary Team) note regarding Resident D;s fall, dated 6/13/2024 at 3:49 P.M., included a description of the incident indicated Resident D's wheelchair was noted to be backed into the shower stall. The foot pedals of the

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F 609	Continued From page 3	F 609		

wheelchair were on with the foot rests in the lowest position. Resident D was dressed in a shirt, pants, shoes and was continent of her bowels and bladder at the time of the fall. The call light was not activated in the room or the bathroom. The resident stated she was taking herself to the bathroom and tripped. Resident D had skin tears noted to both shins and a fracture to her right superior pubic ramus and pubic symphysis bones. The Medical Director and the resident's family member were notified of the change in condition.

Review of the Facility Reported Incident revealed Resident D's incident was submitted to the State agency on 6/13/2024 but there with no 5-day follow-up investigation reported.

During an interview on 7/2/2024 at 8:55 A.M., the Executive Director indicated she did not complete a 5 day follow up of the incident or report the follow up to ISDH (Indiana State Department of Health). She indicated the follow up was completed on 6/24/2024 and should have been completed within five days of the initial report. She indicated she had been re-educated regarding the facility's policy to investigate and submit any reportable issue timely, within the 5 day time frame to the State agency by the Regional Executive team. In addition, a monitoring system was implemented to ensure the reportable investigations were submitted timely in the future.

On 7/2/2024 at 3:19 P.M., the Executive Director provided a policy titled, "Long-Term Care Abuse and Incident Reporting Policy" dated 4/1/2024, and indicated it was the current facility reporting

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F 609	Continued From page 4 policy. The policy indicated, "...2. Follow-up report should include: a. Results of the investigation. b. Interventions implemented or corrective action taken. c. Method in which facility will continue to monitor efficacy of plan/interventions. d. Other persons or agencies to which the incident was reported...." This deficient practice began on 6/18/2024 when the facility failed to complete and submit a timely follow up investigation to the fall for Resident D, which occurred on 6/13/2024. The deficiency was corrected on 6/24/2024 when the facility Administator was re-educted, a follow up investigation report was submitted to the Department of Health and an auditing system was implemented to ensure compliance was acheived. Therefore , the deficient practice was deemed Past Noncompliance This citation relates to complaint IN00434201 3.1-28(e)	F 609		