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	05/28/2025

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00459914, IN00459359, and IN00456664. Complaint IN00459914 - Federal/state deficiencies related to the allegations are cited at F628. Complaint IN00459359 - Federal/state deficiencies related to the allegations are cited at F580. Complaint IN00456664- No deficiencies related to the allegations are cited. Survey dates: May 27 and 28, 2025 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Census Bed Type: SNF/NF: 108 Total: 108 Census Payor Type: Medicare: 13 Medicaid: 93 Other: 2 Total: 108 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 30, 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 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacia Dawson	Executive Director	06/10/2025

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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	Based on interview and record review, the facility failed to timely notify a resident's representative of a medication change for 1 of 3 residents reviewed for changes of condition. (Resident C) Findings include: The clinical record for Resident C was reviewed on 5/27/25 at 10:55 a.m. The diagnoses included, but were not limited to, dementia and rheumatoid arthritis. A Quarterly Minimum Data Set (MDS) assessment, completed 4/9/25, indicated Resident C was cognitively intact. A progress note, dated 1/15/25, indicated nursing staff had reported increased confusion and lethargy since taking Baclofen (a muscle relaxant) 10 milligrams (mg). Due to the resident's fatigue, there was a concern for the use of multiple medications at the same time, and several medications were discontinued, including Baclofen. A progress note, dated 5/6/25, indicated Resident C was experiencing chronic muscle spasms and was taking Tizanidine (medication used to treat muscle spasms) to manage her pain. The resident continued to experience muscle spasms and pain despite the use of the medication. Due to the ineffectiveness of the Tizanidine, Baclofen was to be restarted. A physician's order, dated 5/5/25, indicated to give Baclofen 5 mg, three times a day for muscle spasms. The clinical record for Resident C did not contain documentation of notification to the resident's	F 0580	The facility will ensure this requirement is met through the following plan of action: 1. Resident C's family is aware of medication regimen at this time. 2. All residents have the potential to be affected. An audit will be completed of the last 14 days to ensure all residents/responsible parties have been notified with any medication changes. 3. The Notification Changes policy was reviewed and no changes are indicated. Licensed nursing staff have been re-educated on this policy. The DON or her designee will review 10 residents each week with new orders for 6 weeks and until 100% compliance is achieved, then 10 per month for 6 months and until 100% compliance is maintained to ensure residents/responsible parties are notified of those new orders. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/12/2025

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	representative of the new order for Baclofen 5 mg. A physician's order, dated 5/7/25, indicated to increase the dosage of Baclofen to 10 mg, three times a day for spasms. The clinical record for Resident C did not contain documentation of notification to the resident's representative of the new order for Baclofen 10 mg. The clinical record included special instructions on the resident profile that indicated to notify the family of any medication changes for Resident C. A nursing note, dated 5/9/25 at 3:30 p.m., indicated Resident C appeared confused and semi-conscious throughout the shift. The on-call physician, Director of Nursing (DON), and family were notified, and orders were received to decrease the resident's Baclofen to 5 mg, three times a day. A nursing note, dated 5/10/25 at 7:50 a.m., indicated Resident C's daughter wanted the resident sent to the Emergency Room (ER) due to slurred speech she had witnessed via phone call. Licensed Practical Nurse (LPN) 4 went to the resident's room and found the resident in bed making clear, but repetitive statements, and seemed confused. The resident's vital signs were taken, and she was transferred to the ER at a local hospital. The physician, DON, and family were notified. A nursing note, dated 5/10/25 at 3:00 p.m., indicated Resident C was being admitted to the local hospital for poly pharmaceuticals (the concurrent use of multiple medications), acute encephalopathy (altered mental status), and			

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	hypertensive urgency (severely elevated blood pressure). Hospital records, dated 5/10/25, indicated Resident C was admitted to the ER for acute metabolic encephalopathy (altered mental status) in relation to increased Baclofen dosing. During a confidential interview on 5/27/25 at 1:46 p.m., an anonymous source indicated Resident C's family had not been notified of the resident being restarted on Baclofen on 5/6/25 or of the dosage increase on 5/7/25. During an interview conducted on 5/27/25 at 2:55 p.m. with LPN 4, she indicated Resident C's representative was not notified of the medication (Baclofen) being started on 5/6/25. The resident continued to have pain after starting Baclofen, on 5/6/25, so the dosage was increased. It was LPN 4's understanding that the Nurse Practitioner was to notify the family of medication changes. During an interview on 5/27/25 at 3:15 p.m., the DON indicated nursing staff was to notify resident's family of medication changes when the resident was not their own person. A Notification Changes Policy, last revised 10/21/24, was provided by the DON on 5/27/25 at 3:44 p.m. It indicated " ...The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification ...Circumstances requiring notification include: ...3. Circumstances that require a need to alter treatment. This may include: a. New treatment b. Discontinuation of current treatment due to: i. Adverse			

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	consequences ii. Acute condition. iii. Exacerbation of a chronic condition ..." This citation relates to Complaint IN00459359. 3.1-5(a)(3)			
F 0628 SS=D Bldg. 00	483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 48 Discharge Process Based on interview and record review, the facility failed to document the reason for transferring a resident to a local hospital and ensured communication to the receiving health facility for 1 of 3 residents reviewed for discharge rights. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/27/25 at 10:30 a.m. The diagnoses included, but were not limited to, multiple sclerosis and hypertension. A care plan, last revised on 4/15/25, indicated Resident B's plan was to discharge home with her spouse. The goal was for her to be discharged home. The interventions included, but were not limited to, arrange for and set up community resources and to educate her on her clinical condition and medications as needed. A Medicare Part A Discharge Minimum Data Set (MDS) assessment, completed 5/5/25, indicated Resident B's Medicare Part A payment coverage ended on 5/5/25. A physician's order, dated 5/5/25, indicated Resident B was to be evaluated and treated by hospice services.	F 0628	The facility will ensure this requirement is met through the following corrective measures: 1. Resident B has returned to the facility. She was not harmed. 2. All residents have the potential to be affected. 3. The Transfer/ Discharge Policy was reviewed and no changes are indicated. Licensed nursing staff have been re-educated on this policy. The DON or her designee will audit 5 (or all, if less than 5) transfers weekly for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained to ensure documentation is present regarding reason for transfer and copies are retained of what information was sent with the resident. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/12/2025

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A physician's order, dated 5/5/25, indicated she was not to be resuscitated (DNR).

A Physician's Narrative Progress Note, effective 5/5/25 at 9:18 a.m., indicated Resident B had been seen for lethargy, difficulty swallowing medications, and having hallucinations. Resident B was no longer able to participate in therapy. A discussion was held with Resident B's family member and an acute work up in the facility was offered verses a palliative (end of life) care and hospice option were offered. Resident B's family member would like to make her mother comfortable. New orders were discussed with nursing staff and a plan for hospice care was discussed with social services.

A physician's order, dated 5/6/25, indicated to admit Resident B to a local hospice service.

A Nursing Progress Note, dated 5/6/25, indicated Resident B had staples removed from her left below the knee amputation site and the surgical incision was proximal (together). There were no open areas noted and the skin around the incision site was dry and flakey. Resident B had tolerated the procedure with no difficulty.

A Nursing Progress note, dated 5/6/25 at 11:30 p.m., indicated Registered Nurse (RN) 3 had been instructed to send Resident B to the emergency room due to a decline in her condition.

The clinical record did not contain a physician's order to send Resident B to the hospital, on 5/6/25, and did not contain a Situation, Background, Assessment, and Recommendation (SBAR) form indicating the decline in her condition.

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A Nursing Progress note, dated 5/7/25 at 1:38 a.m., indicated the Emergency Room (ER) nurse had contacted the facility to ask why Resident B was sent to the ER.

A Nursing Progress note, dated 5/7/25 at 2:02 a.m., indicated the acute care hospital social worker had called with questions about Resident B and requested to speak to the Director of Nursing. The Director of Nursing was notified.

A Nursing Progress note, dated 5/7/25 at 10:24 a.m., indicated Resident B had returned from the hospital. She was conscious but not alert. There were no new orders received from the hospital.

During an interview on 5/27/25 at 11:15 a.m., Family Member (FM) 10 indicated Resident B had been sent to the ER, the night of 5/6/25, due to an outstanding bill with the facility. Resident B had a change in condition and was unable to return home when her therapy was over. The facility's Social Services Director (SSD) and Business Office Manager (BOM) had spoken with FM 10 about an outstanding balance. FM 10 had made the facility aware that she was attempting to contact an attorney to obtain guardianship of Resident B so she could access Resident B's funds and pay the outstanding balance. The facility had informed FM 10 that if the balance was not paid by midnight, on 5/6/25, that Resident B would be discharged to an inpatient hospice program.

During an interview on 5/27/25 at 12:14 p.m., Licensed Practical Nurse (LPN) 5 indicated normally when a resident was sent to the hospital, an SBAR form was completed to communicate the reason for the transfer or the change in condition.

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	Resident B did not have an SBAR in her medical record for the transfer on 5/6/25. During an interview on 5/27/25 at 3:00 p.m., the SSD indicated Resident B had not been issued a 30-day discharge notice. Her stay at the facility had been financially covered by Medicare Part A. Her condition had declined, and she was no longer able to participate in therapy. The Nurse Practitioner had approached the SSD, on 5/5/25, and requested that Resident B be referred to hospice. The SSD had made contact with a hospice company that provided services at the facility about a referral. The SSD had also spoken with Resident B's family about hospice and about an outstanding balance. The SSD had suggested that an inpatient hospice may be an option for Resident B due to her outstanding balance. Resident B's family had been working with the facility to provide payment. The SSD was unsure why Resident B had been sent to the ER at the late hour on 5/6/25. During an interview on 5/27/25 at 3:07 p.m., the Director of Nursing (DON) indicated Resident B had been transferred to the ER, on 5/6/25, so that she could be admitted to the hospital's inpatient hospice. Resident B had experienced a gradual change in condition and the DON was expecting Resident B to be transferred to an inpatient hospice. The DON had been made aware that Resident B was still at the facility in the late evening, on 5/6/25, and had instructed the nurse on duty to send Resident B to the ER department so that she could be admitted to an inpatient hospice. The DON was not sure of the admission process for inpatient hospice and had been concerned that transportation had not come to transport Resident B.			

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	During an interview on 5/27/25 at 3:07 p.m., the BOM indicated that a 30-day notice had not been issued to Resident B. There was an outstanding balance on Resident B's account. During an interview on 5/27/25 at 3:07 p.m., the Executive Director (ED) indicated the facility was attempting to assist the family from accruing a large bill. During an interview on 5/28/25 at 9:22 a.m., RN 3 indicated she had been Resident B's nurse during the night shift of 5/6/25. She had been instructed by the DON to send Resident B to the ER right after she had started her shift. RN 3 was not sure why Resident B was sent to the hospital. The hospital nurse and the hospital social worker called the facility after Resident B arrived at the hospital to ask why she had been sent to the hospital. Resident B returned to the facility on 5/7/25 at around 5:00 a.m. During an interview on 5/28/25 at 10:00 a.m., LPN 2 indicated she had cared for Resident B during the evening shift on 5/6/25. There were no acute changes in Resident B on the evening of 5/6/25. LPN 2 had been informed that Resident B may be transferred out of the building to an acute inpatient hospice service but had not been transferred during the evening shift. Resident B had been stable when LPN 2 ended her shift on 5/6/25. Nothing acute happened during the shift. During an interview on 5/28/25 at 11:05 a.m., the ED indicated there was some confusion with Resident B's transfer on 5/6/25. The facility was trying to do the right thing so that the family would not accrue a large bill. During an interview on 5/28/25 at 11:13 a.m., FM			

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	10 indicated she had not had a formal discharge meeting. While FM 10 was visiting with Resident B, the evening of 5/6/25, a nurse had informed her that if payment of the outstanding balance was not received by midnight that night, Resident B would be discharged. During an interview on 5/28/25 at 12:35 p.m., the DON indicated the clinical record did not include information about what information was sent to the hospital with Resident B on 5/6/25. On 5/27/25 at 3:44 p.m., the DON provided the Transfer and Discharge (including AMA) Policy, last reviewed 2/5/25, that indicated "...Once admitted, the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility. c. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. d. The health of the individuals in the facility would otherwise be endangered. e. The resident has failed, after reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for his or her stay at the facility...f. The facility ceases to operate...4. Generally, the notice must be provided at least 30 days prior to a transfer or discharge of the resident. 10. a. The facility will obtain a physician's order for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis...f. Document assessment findings and other relevant information regarding the transfer in the medical			

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	record..." This citation relates to Complaint IN00459914. 3.1-12(a)(4)(A) 3.1-12(a)(4)(E) 3.1-12(a)(5) 3.1-12(a)(6)(B)			