STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	02/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 5, 6, 7, 8, and 9, 2024 Facility number: 012329 Provider number: 155784 AIM number: 201002500 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 11 Medicaid: 53 Other: 23 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/14/24.	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The facility is requesting a desk review in lieu of post survey revisit on or after 3/10/2024.**	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a			

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

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	resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on observation, interview, and record review, the facility failed to create a Baseline Care Plan related to a resident whose native language was not English, and a resident with methicillin-susceptible staphylococcus aureus (MSSA), for 2 of 19 residents who were reviewed	F 0655	**F655- Baseline Care Plan** It is the policy of this facility to implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care	03/10/2024

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	for Baseline Care Plans. (Residents 55 & 244) Findings include: 1. During an observation, on 2/5/2024 at 11:16 A.M., Resident 55 was on a video call speaking Gujarati on a personal cell phone. No picture board or language line was present in his room. During an interview, on 2/5/2024 at 11:16 A.M., Resident 55's daughter indicated her father does not speak English, and did not always understand what staff was saying, unless a family member was present to translate. A record review was completed, on 2/8/2024 at 3:31 P.M. Resident 55's diagnoses included, but were not limited to: hemiplegia and hemiparesis of dominant side, cognitive communication deficit, dysphagia, and aphasia. An Admission MDS (Minimum Data Set) assessment, dated 1/15/2024 indicated Resident 55 had severe cognitive impairment. Resident 55's preferred language was Hindi. Resident 55's record lacked any documentation that a Baseline Care Plan for communication was created. During an interview, on 02/09/24 at 9:59 A.M., the Executive Director indicated Resident 55 did not have a Baseline Care Plan for communication, but should have. On 2/9/2024 at 8:25 A.M., the Executive Director provided a policy dated, 5/2019, and titled, "Communication Barriers/Interpreter Services Policy". The Executive Director indicated the		of the resident. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** A care plan for resident 55 was added regarding his communication preferences. A care plan for resident 244 was added regarding his infection. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All newly admitted residents have the potential to be affected by this finding. MDS Coordinator/designee will review new admissions in last 14 days to check for accuracy and timely completion of the base line care plan related to infections and communication preferences. Any concerns identified will be addressed at that time. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for the interdisciplinary team will be held on or before 3/10/24 by the DNS or designee. This in-service will include review the policy titled Comprehensive Care Plan Policy. IDT will review all new admission care plans to ensure all concerns	

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	policy was the one currently used by the facility. The policy indicated, "...2. For resident's whose native language is not English, the IDT will determine alternate methods for communication and comprehension. These methods will be added to the plan of care...." 2. A record review, on 2/07/2024 at 9:23 A.M., indicated Resident 244 was admitted to the facility on 1/30/2024. The resident's diagnoses included, but were not limited to: MSSA (Methicillin-resistant Staphylococcus Aureus) of the left knee replacement with bacteremia (contagious bacterial infection), COVID, Respiratory failure, Atrial Fibrillation, left big toe and 2nd left toe tip gangrene. A Care Plan, dated 1/31/2024, indicated Resident 244 had impaired skin integrity related to surgical incisions to left medial and lateral knee, and required assistance with mobility, transfers, and toileting, but did not indicate the resident required contact precautions due to MSSA of the left knee. A Physician's Order, dated 2/3/2024, indicated the resident was to be in contact isolation, due to having an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission, related to MSSA in wound. During an interview, on 2/9/2024 at 1:11 P.M., the Director of Nursing indicated the resident should have had a care plan in place for contact isolation due to MSSA in his wound and did not. A policy provided by the Administrator, on 2/8/2024 at 1:18 P.M., titled "IDT Comprehensive		are identified and addressed on the base line care plan. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The MDS Coordinator/Designee will be responsible for completing the QAPI Audit tool titled, “Baseline Care Plan Initiation” weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 3/10/24	

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	Care Plan Policy", dated 8/2023 and indicated this is the current policy used by the facility. The policy indicated, " ...The care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being ...Improve relationships between resident, families and/or representative, and facility caregivers through understanding if resident's social history, culture and preferences to enhance the resident's life ...." 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in			

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	disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure comprehensive care plans were updated related to self administration of eye drops, isolation, and NPO (nothing by mouth) status, for 3 of 22 residents whose care plans were reviewed. (Residents 20, 244, & 30) Findings include: 1. A record review was completed on 2/8/2024 at 11:32 A.M. Resident 20's diagnoses included, but were not limited to dry eye syndrome, diabetes, hypertension, and chronic pain. Resident 20's current Physician Orders included: Refresh plus eye drops 0.5% to both eyes BID (twice per day). A current Care Plan, with a revised date of 1/12/2024, indicated the resident had impaired vision and utilized glasses. An intervention, dated 5/4/2018, indicated the resident self-administered artificial tears for diagnosis of dry eyes, and kept the artificial tears at bedside. During an interview, on 2/9/2024 at 10:40 A.M., the Unit Manager indicated the resident did not self-administer eye drops. During an interview, on 2/9/2024 at 10:41 A.M., QMA 11 indicated the resident did not self-administer her eye drops, the nurse or the QMA administered the eye drops.	F 0657	**F657- Care Plan Timing and Revision** It is the practice of the facility to ensure all residents have an up to date comprehensive care plan. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 20 care plan was updated and was no longer applicable and are resolved Resident 244 care plan was updated to indicate resident is no longer in isolation per MD order and care plan is resolved. Resident 30 care plan was updated to indicate resident will eat at least 75% of meals was deleted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding**.** MDS/designee will review all care plans which indicate self administration of medication, isolation due to COVID and resident with wounds to ensure accuracy of the care plan	03/10/2024

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	During an interview, on 2/9/2024 at 10:42 A.M., the MDS Coordinator indicated the care plan should have been updated. 2. A record review, on 2/07/2024 at 9:23 A.M., indicated Resident 244 was admitted to the facility on 1/30/2024. The resident's diagnoses included, but were not limited to: MSSA (Methicillin-resistant Staphylococcus Aureus) of the left knee replacement with bacteremia (contagious bacterial infection), COVID, Respiratory failure, Atrial Fibrillation, left big toe and 2nd left toe tip gangrene. A Physician's Order, dated 1/31/2024, indicated the resident was to be in droplet/contact isolation due to having an active COVID infection. The order was discontinued on 2/2/2024. A Care Plan, dated 1/31/2024, indicated the resident remained in droplet/contact isolation related to COVID-19. During an interview, on 2/9/2024 at 1:11 P.M., the Director of Nursing indicated that the care plan should have been updated after the resident no longer had COVID and the COVID isolation had been discontinued. 3. A record review for Resident 30 was completed on 2/07/2024 at 9:09 A.M. Diagnoses included, but were not limited to: encephalopathy, neuroleptic induced Parkinsonism, dysphagia, hemiplegia, and hemiparesis following cerebral infarction (stroke). An Admission Minimum Data Set (MDS) assessment, dated 12/26/2024, indicated Resident 30 had an intact cognition. The resident had a feeding tube and more than 50% of food intake was via the feeding tube.		IDT team will review all care plan problems, goals and interventions following the completion of each MDS assessment. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for the IDT team will be held on or before 3/10/24 by the DNS or designee. This in-service will include review the policy titled Comprehensive Care Plan Policy. IDT will review care plans when a change of condition occurs to ensure care plans are up to date to reflect the change. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, “Care Plan Update QAPI” weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and	

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	Physician Orders included the following: on 12/22/2023, Resident 30 was to have nothing by mouth. On 1/3/2023, the resident was to receive Jevity 1.5 at 65 milliliters (ml) per hour continuously via a gastrostomy tube. A Care Plan, dated 1/28/2024, indicated the resident had a risk for skin breakdown. Interventions included, but were not limited to, " ...encourage resident to eat at least 75% of meals ...." During an interview, on 2/08/2024 at 10:56 A.M., the MDS Coordinator indicated that the intervention for consuming 75% of meals was preloaded on the wound care plan and should have been updated to reflect the resident's current condition and physician orders. A current policy, provided on 2/8/2024 at 1:18 P.M. by the Administrator, titled "IDT Comprehensive Policy" and dated 8/2023 indicated, " ...Create an organized, resident-centered review on a routine basis to improve communication with residents, resident families and/or representative regarding the resident goals, total health status, including functional status, nutritional status, rehabilitation and restorative potential, ability to participate in activities, cognitive status, psychosocial status, sensory and physical impairments, as well as care and services provided to maintain or restore health and well-being, improve functional level or relieve symptoms ...." 3.1-35(d)(2)(B)		follow-up. **By what date the systemic changes will be completed:** Compliance date = 3/10/24	
F 0756 SS=D	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act			

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Bldg. 00	On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the			

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	pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on observation, interview, and record review, the facility failed to follow the Pharmacist's Recommendation related to the use of a diuretic medication, for 1 of 5 residents review for unnecessary medications. (Resident 8) Finding includes: A record review for Resident 8 was completed on 2/07/2024 at 10:57 A.M. Diagnoses included, but were not limited to, acute on chronic congestive heart failure. A Quarterly Minimum Data Set (MDS) assessment, dated 11/12/2023, indicated Resident 8 received a diuretic medication daily. A Physician Order, dated 5/30/2023\, indicated furosemide (diuretic) 40 milligrams (mg) orally once a day. A Pharmacy Recommendation, dated 7/27/2023, indicated Resident 8 experienced 2 falls in July 2023 and had received a medication that may cause low blood pressure. The recommendation indicated to monitor orthostatic blood pressures periodically. The Medication Administration Record (MAR) for August, September, October, and November 2023, indicated Resident 8's blood pressure was checked every other day. The MAR did not indicate the blood pressures were orthostatic. The order was discontinued on 11/7/2023. The record lacked documentation of any blood pressures for the remainder of November 2023,	F 0756	**F756- Drug Regimen Review** It is the practice of the facility to ensure that all pharmacy recommendations are followed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Nursing intervention was implemented and to obtain vital signs weekly for Resident 8. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All long term residents have the potential to be affected by this finding. DNS/ designee will complete an audit of all pharmacy recommendations in last 30 days to ensure all recommendations have been followed by the facility. DNS/designee will audit all long term residents to ensure that a nursing order is in place for weekly vital signs to be taken. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for the IDT team will be held on or before 3/10/24 by the DNS or designee. This inservice will include	03/10/2024

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	December 2023, January 2024, and through February 7, 2024. During an interview, on 2/7/2024 at 2:13 P.M., the Director of Nursing (DON) indicated blood pressures should have been done and documented in the vital sign section of the clinical record, and would check to see if they were documented elsewhere. On 2/7/2023 at 2:20 P.M. the DON indicated she could not find blood pressures documented in the clinical record and that vital signs should be done monthly, but were not. On 2/8/2024 at 12:13 P.M., the Administrator indicated there were no specific policies for following pharmacy recommendations or obtaining routine vital signs. 3.1-25(i)		implementation of nursing measure per pharmacy recommendations. DNS/designee will review pharmacy recommendations daily to ensure nursing measures are implemented and documented in the resident medical record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, "Pharmacy Recommendations" weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 3/10/24	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated			

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	with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic			

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	155784	A. BUILDING 00 B. WING	02/09/2024

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

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	drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure a resident's psychotropic medication was not increased and deemed a failed GDR (gradual dose reduction) without adequate indication/documentation and other non-pharmacological interventions consistently implemented by facility staff, for 1 of 5 residents reviewed for unnecessary medications. (Resident 33) Finding includes: A record review was completed on, 2/7/2024 at 11:45 A.M. Resident 33's diagnoses included, but were not limited to cerebral palsy, Schizophrenia, depression, and anxiety. Resident 33's medication orders included, Seroquel (anti-psychotic) 25 mg (milligrams) every night, ordered 1/13/2023 as a GDR. A current Care Plan, with a revised date of 1/5/2024, indicated Resident 33 displays delusions/hallucinations as evidence by seeing people/things in his room and making up stories about his past. Misperceptions of staff actions or responses. He has a diagnosis of Schizophrenia with an order for anti-psychotic medication. A current Care Plan, with a revised date of 1/5/2024, indicated the resident was at risk for s/s (signs and symptoms) of depression related to feeling bad about his decline in health and inability to perform ADLs (activity of daily living) for himself. He calls for staff if he feels lonely, has a diagnosis of depression, and receives as	F 0758	**F758- Free from Unnecessary Psychotropic Medications** **The facility is requesting an IDR related to this deficiency.** **The facility followed the policy for psychotropic medications.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 33 was seen by psych services and a GDR was done on Seroquel. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents receiving a psychotropic medication have the potential to be affected by this finding. Social Service Directors/ designee will complete an audit of all residents receiving psychotropic medications to ensure that those residents have the appropriate diagnosis or behavioral symptoms present for med use, that non pharmacological interventions are listed on their care plan and a GDR has been attempted or requested per regulations. **What measures will be put into place or what systemic**	03/10/2024

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	antidepressant medication. A current Care Plan, with a revised date of 1/5/2024, indicated the resident displays s/s of anxiety related to a diagnosis of anxiety, as evidenced by calling out, heavy breathing, SOB (short of breath), difficulty communicating his thoughts, feeling overwhelmed and crying. He utilizes anxiety medication. A Visit Note Report, dated 1/25/2023 and completed by the Hospice Social Worker (HSW), indicated for the behavioral assessment findings, the documentation was checked as "None of the Above Behaviors Demonstrated. What symptoms area causing the most distress- pain and insomnia." A Visit Note Report, dated 1/31/2023 and completed by the HSW, indicated for the behavioral assessment findings, the documentation was checked as "None of the Above Behaviors Demonstrated." A Narrative Note, indicated the nurse reported he had ongoing anxiety and yelling out, especially during the night shift. The HSW encouraged staff that the resident would likely benefit from a psychosocial intervention, i.e. spending time with him. A Social Service Note, recorded as a late entry on 2/4/2023 at 9:45 A.M., indicated: "Description of behavior: Increase in restlessness and yelling out. Immediate interventions: Provide calm reassurance; offer fluids Assessment of potential correlation to root cause: Psychosocial factors [activity participation, change in visitors, stressors, trauma history], Environment [over/under stimulation, approach, positioning, other resident behavior], Medications		**changes will be made to ensure that the deficient practice does not recur:** An in-service for the Nursing staff and IDT team will be held on or before 3/10/24 by the DNS or designee. This in-service will include review the policies titled "Behavior Management" and "Psychotropic Management" All unsuccessful GDR will be reviewed by Social Service Director /Designee to ensure non-pharmacological interventions were attempted and were unsuccessful and documented in the clinical record **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, "Psychotropic Medications" weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic**	

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	[potential adverse side effects, recent changes], Psychiatric conditions [depression, anxiety, psychosis, etc]. Potential correlation(s) to root cause: Possible over stimulated related to visitors in room; recent GDR of Seroquel. Root cause of behavioral expression: Dx. [diagnoses]: Schizophrenia; possible failed GDR. Describe preventative intervention relating to above root cause: Continues to receive hospice care and monitored for behaviors; Seroquel increased due to failed GDR. Care plan updated and current interventions revised as applicable: Yes." A New/Worsening Behavior Communication Event, dated 2/4/202 at 6:00 P.M., indicated at 6:00 P.M., Resident 33, had a behavior of increased in restlessness and yelling out. Under the section of: Describe the specific type of behavior that occurred, the documentation indicated: "yelling out increase in anxiety and restlessness. Resident was given candy and pop from sister during visit." Intervention put into place to prevent another behavior was documented as follow up with hospice weekly and PRN (as needed). A Nursing Progress Note, dated 2/4/2023 at 7:01 P.M., indicated the on call Hospice Nurse came out and assessed the resident's condition. Staff received and noted a new order for Seroquel 25 mg BID (twice a day) and at night. Resident 33 was already on Seroquel 25 mg every night. A Visit Note Report, dated 2/4/2024 and completed by the Hospice RN, indicated Resident 33 had no abnormal mood/effect identified. No abnormal psychiatric symptoms identified. No change in the resident's depression, and anxiety did not significantly affect the resident. In the narrative section, the following was documented: "Per facility nurse resident had been yelling out all		**changes will be completed:** Compliance date = 3/10/24	

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	day about back pain, even with increased doses. Especially when family was around. Spoke with [name of doctor], he ordered Seroquel 25 mg BID (twice a day)." On 2/5/2023 the Seroquel order was increased to 25 mg BID (twice a day). A Nurses' Progress Note, dated 2/5/2023 at 6:35 P.M., indicated, the resident's "yelling out continued for a bit this morning, but shortly after all medications given as ordered resident seemed to be calmer. No family at bedside with any type of sugary snacks and/or drinks. Just an observation made by staff that resident often becomes very antsy and restlessness after either sister or nurse from Hospice visits and always gives some type of sugary snack or drinks. Resident soon becomes very restless and antsy and the yelling out usually begins." During an interview, on 2/9/2024 at 9:21 A.M., CNA 6 indicated the resident usually had a behavior maybe 2 times a month, usually after his sister was here. CNA 6 indicated she would give him pop or talk to him, which would help with those behaviors. During an interview, on 2/9/2024 at 10:46 A.M., the Social Service Director (SSD) indicated the Seroquel was increased due to a failed GDR (gradual dose reduction). The resident had increased agitation and yelling," but it was his normal behaviors". She indicated Pharmacy would send the facility the recommendations and staff review them in the monthly meeting. A Social Service Annual Assessment Note, dated 3/15/2023, indicated. "Behavioral Expressions: sometimes yells out at staff in place of using call			

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	light. Psychosocial Assessment: diagnoses: Schizophrenia, anxiety, depressive disorder. Behavioral Health Concerns: n/a." A Behavior Health Monthly Review, dated 3/22/2023, indicated "New/Worsening Behaviors Exhibited: 2/4/2023 increase in restlessness and yelling out. What is the targeted behavior for each medication: agitation and yelling." On 2/9/2024 at 10:47 A.M., when asked for other monthly Behavior Review Meeting Notes other than 3/2023 and 11/2023, the SSD indicated all she had were in the chart and there was no further information. No other Behavior Health Monthly Review forms were located. There was no behavior monitoring documentation of any ongoing, frequent behaviors by facility staff after the initial GDR on 1/13/24, or any consistent non-pharmacological interventions implemented prior to deeming a "failed GDR" and increasing the Seroquel on 2/5/24. On 2/9/2024 at 1:15 P.M., the Administrator provided the policy titled,"Psychotropic Management", dated 7/2022, and indicated the policy was the one currently used by the facility. The policy indicated"... These medications are managed in collaboration with professional services and facility staff to include non pharmacological interventions, assessment, and reeducation as applicable... 1. Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed... 4. For antipsychotropic medications, diagnoses alone do no necessarily warrant the use these of these medications. Antipsychotic medications may be indicated if: ...c Non			

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	pharmalogical approaches have been attempted, but did not relieve the symptoms which are presenting a danger or significant distress... 6. Psychotropic medications may be considered regularly for potential GDR including during monthly pharmacy reviews, during behavioral health services visits, and when the IDT is evaluating behavioral expressions...." On 2/9/2024 at 1:15 P.M., the Administrator provided the policy titled," Behavior Management", dated 8/2022, and indicated the policy was the one currently use by the facility. The policy indicated"...3. When a behavioral expression occurs, the staff communicate to the nurse what behavior occurred. The nurse records the behavior in Matrix (charting system). 4. If the behavioral expression is new, worsening, or high risk. the nurse will record the behavior using the New/Worsening Behavior Event. New or worsening behaviors are reviewed by the IDT for assessment an preventative actions. New/Worsening Behaviors include: a. Behaviors that are new for the resident. b. Behaviors that are directed at another resident. c. Behaviors that are increasing in either frequency or severity. d. Behaviors that have potential for risk to others including sexual advances, intrusive wandering, exit seeking and chronic combativeness with care. The IDT review is a discussion with the team as to the behavioral expression, and evaluation of interventions if applicable and an assessment of any underlying causes of the behavior (i.e. pain, environmental stressor, medical illness, etc).. 6. Residents with documented behaviors will have a Behavioral Health Monthly Review. This review includes evaluation of behaviors which have occurred that month and that interventions for behavioral expressions are current and effective...."			

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	3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medication carts were free from loose pills and failed to date opened medications in 2 of 3 medication carts observed. (Halls 100 & 200) Findings include:	F 0761	**F761 – Label/Storage Drugs and Biologicals** It is the practice of the facility to ensure all medications are labeled appropriately and no personal items are stored in med carts or med rooms. **What corrective action(s) will**	03/10/2024

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	1. A medication storage observation was completed, on 2/6/2024 at 10:55 A.M. with LPN 5, on the 100 Hall medication cart. The following was observed: - 10 loose pills in various drawers. - An opened and undated bottled of latanoprost eye drops. - An opened and undated bottle of potassium chloride. - An opened and undated bottle of refresh tears. During an interview, on 2/6/2024 at 11:03 A.M., LPN 5 indicted the loose pills should not be in the cart and the medications should have been dated when opened. 2. A medication storage observation was completed, on 2/6/2024 at 1:52 P.M. with LPN 3, on the 200 Hall medication cart. The following was observed: 2 loose pills in the drawer. During an interview, on 2/6/2024 at 2:00 P.M., LPN 3 indicated the loose pills should not be in the drawers. On 2/9/2024 at 11:17 A.M., the Administrator provided the policy titled,"Medication Administration", dated 7/2023, and indicated the policy was the one currently used by the facility. The policy indicated"... 7. Medications with shortened expiration dates,(e.g., insulin, eye drops) have date opened on the medication label...." On 2/9/2024 at 11:17 A.M., the Administrator provided the policy titled," Storage and Expiration Dating of Medications and Biological's", dated 7/21/2022, and indicated the policy was the one currently used by the facility. The policy indicated..." 5. ...Facility staff should record the		**be accomplished for those residents found to have been affected by the deficient practice:** All loose pills were disposed of properly and medications in question were disposed of properly and new medication was received and dated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. DNS/ designee will complete an audit of all medication carts to ensure medication is labeled appropriately per policy and free of debris and/or loose pills. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for all nursing will be held on or before 3/10/24 by the DNS or designee. This in-service will include review the policy titled Storage and Expiration of Medications, Biologicals. DNS/designee will review medications in med carts on a weekly to ensure appropriately labeled and dated, and that there are no loose pills in the med carts. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened... 16 Facility should destroy or return all discontinued, outdated/expires or deteriorated medications or biological's in accordance with Pharmacy return/destruction guidelines and other Applicable law... 17. Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis.... 3.1-25(j) .		**recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, “Medication Storage Audit” weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 3/10/24	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			

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	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure proper infection control practices were completed during 1 of 1 blood sugar checks observed. (LPN 2) Finding includes: On 2/7/2024 at 10:58 A.M., LPN 2 completed a blood sugar check of Resident 43. LPN 2 placed the accucheck device on the bedside table. He cleansed his hands with alcohol gel and applied gloves. LPN 2 then cleansed Resident 43's finger with an alcohol pad, and with an opened hand, fanned the area that was just cleansed. During an interview, on 2/7/2024 at 11:07 A.M., LPN 2 indicated he should not have fanned the area. On 2/9/2024 at 11:17 A.M., the Administrator provided the policy titled,"Blood Glucose Meter Testing", dated 7/2011 and revised 1/2024, and indicated the policy was the one currently used	F 0880	**F880 – Infection Prevention and Control** It is the practice of the facility to establish and maintain an infection prevention and control program designed to provide a safe, comfortable environment and to help prevent the transmission of communicable diseases and infections. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** LPN 2 was provided immediate education regarding Blood Glucose Meter Testing Procedure. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents that are tested with	03/10/2024

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	by the facility. The policy indicated"...8. Cleanse resident's fingertip with alcohol wipe and allow to air dry...." 3.1-18(a)		Blood Glucose Meter have the potential to be affected by this finding. All licensed nurses and QMAs will receive skills check off on Blood Glucose Meter Testing procedure. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for all nursing will be held on or before 3/10/24 by the DNS or designee. This in-service will include review the skills check off titled Blood Glucose Meter Testing Procedure. DNS/Designee will conduct rounds daily to ensure appropriate infection control measures are followed. . **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS /Designee will be responsible for completing the QAPI Audit tool titled, “Blood Glucose Meter Testing Skills Competency” weekly for 4 weeks and monthly for 6 months. If threshold of 100% is not met, an action plan will be developed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	02/09/2024

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

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			Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed:** Compliance date = 3/10/24	