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	05/19/2021

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

(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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00351254, IN00351434, IN00353151, and IN00353741. Complaint IN00351254- Substantiated. Federal/State deficiencies related to the allegations are cited at F550, F610, F677, F684, and F697. Complaint IN00351434- Substantiated. Federal/State deficiencies related to the allegations are cited at F550, F610, F656, F677, F684, F697, and F756. Complaint IN00353151- Substantiated. No Federal/ State deficiencies are cited related to the allegation. Complaint IN00353741- Substantiated. Federal/State deficiencies related to the allegations are cited at F550, F610, F656, F677, F684 and F697. Survey dates: May 11, 12, 13, 14, 17, 18, and 19, 2021 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type: Medicare: 17	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.**	

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

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	05/19/2021

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

(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
	Medicaid: 80 Other: 6 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 27, 2021			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.			

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	05/19/2021

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

(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
	§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to maintain a resident's dignity be removing her hospital bands for 1 of 4 residents reviewed for dignity. (Resident K) Findings include: The clinical record for Resident K was reviewed on 5/12/21 at 10:00 a.m. The diagnoses included, but were not limited to: end stage renal disease, type 2 diabetes mellitus and acute respiratory failure. The resident was readmitted to the facility on 4/8/21. An observation was made of Resident K on 5/12/21 at 10:14 a.m. A faded white hospital band was observed on Resident K's left arm and a pink hospital band was on her right arm. Resident K indicated the hospital bands have been on since she was admitted. She would like them off. An observation was made of Resident K on 5/19/21 at 10:21 a.m. The resident's right arm had a white faded hospital band, and her left arm had a pink hospital band.	F 0550	1. Due to anonymity of the residents, see #2 below. 2. All residents have the potential to be affected. All residents have been checked to ensure they are not wearing any hospital identification. 3. The Administrator or his designee will check 10 residents per week for 4 weeks and until 100% compliance to ensure that hospital identification has been removed, then 10 residents per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/18/2021

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	05/19/2021

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

(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
	An interview was conducted with License Practical Nurse (LPN) 2 on 5/19/21 at 10:30 a.m. She indicated she wasn't aware Resident K had hospital bands on both arms. She would remove. A "Resident Rights" policy was provided on 5/19/21 at 2:00 p.m. It indicated "...Basic rights...You have the right to be treated with respect and dignity in recognition of your individuality and preferences..." This Federal Tag relates to complaints IN00351254, IN00351434, and IN00353741. 3.1-3(t)			
F 0552 SS=D Bldg. 00	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options			

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	05/19/2021

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

(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
	and to choose the alternative or option he or she prefers. Based on observation, interview, and record review, the facility failed to involve a resident in her care by not listening to her and verifying her concerns prior to checking her blood sugar for 1 of 1 resident randomly observed. (Resident H) Findings include: The clinical record for Resident H was reviewed on 5/12/21 at 11:00 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis. Resident H's physician's orders did not include an order to check her blood sugar. An interview and observation was conducted with Resident H on 5/18/21 at 4:20 p.m. During the interview, QMA (Qualified Medication Aide) 12 entered the room at 4:26 p.m. QMA 12 informed Resident H she was there to check her blood sugar. Resident H asked QMA 12 if she was new to the facility. QMA 12 informed her she was from an agency. Resident H informed QMA 12 she did not normally get her blood sugar checked and asked QMA 12 if, perhaps, she was supposed to check her roommate's blood sugar, because he received blood sugar checks, but she did not. QMA 12 informed Resident H that the nurse at the desk told her to check the blood sugar of the female in the room. QMA 12 proceeded to check Resident H's blood sugar on her finger, announced it was 98, then left the room. Resident H had a shocked look on her face throughout the interaction with QMA 12. After QMA 12 left the room, Resident H indicated she hadn't had her blood sugar checked in months.	F 0552	1. Resident H's identity is known to the facility. Social services to follow-up with resident to ensure no mental anguish. 2. All residents have the potential to be affected. See below for corrective measures. 3. Staff will be educated on Resident's Rights. The DON or her designee will interview 10 random residents weekly as to whether staff are listening to them and no unnecessary treatments/labs are performed. Audits will continue for 4 weeks and until 100% compliance is achieved, then 10 residents per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented at the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/18/2021

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	05/19/2021

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

(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
	An interview was conducted with LPN (Licensed Practical Nurse) 13 at the nurse's desk on 5/18/21 at 4:31 p.m. LPN 13 indicated she told QMA 12 to check the male's blood sugar in the room, not the female's. LPN 13 provided a small piece of paper with 6 room numbers with blood sugar results next to them, including Resident H's room with an F with a line through it to the left of Resident H's room number and a 98 to the right of Resident H's room number. The physician's orders for Resident H's roommate indicated to check his blood sugar daily one time a day for diabetes mellitus. An interview was conducted with the NC (Nurse Consultant) on 5/18/21 at 4:45 p.m. She indicated QMA 12 should have listened to Resident H, when she said she didn't get blood sugar checks. The Glucose Meter Cleaning & Testing policy was provided by the NC on 5/19/21 at 11:12 a.m. It read, "Obtaining blood sugar results: 1. Verify order." 3.1-3(n)(3)			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to have the Interdisciplinary team (IDT) determine and document a self-medication assessment was	F 0554	1. Resident S is known to the facility and was not harmed. Resident S administers insulin. Resident S has been reassessed for self-administration and was	06/18/2021

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	05/19/2021

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

(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
	clinically appropriate for 1 of 1 resident randomly observed with medications at the bedside. (Resident S) Findings include: An observation of Resident S's room was made on 5/17/21 at 9:26 a.m. On top of Resident S's bedside table, there were two plastic medication cups. One medication cup contained 6 unidentified pills. The other medication cup contained a pink liquid. An interview with Resident S was conducted at the same time and date of the observation. Resident S indicated; she did not know what the medications were inside the two medication cups that were left at her bedside. She further stated, she cannot take her medications until she had finished her breakfast. An interview with UM (unit manager) 17 was conducted on 5/17/21 at 9:32 a.m., inside Resident S's room. UM 17 indicated, Resident S had a self-administration evaluation for insulin only and not any other medications. She further stated, the two cups of medication should not have been left at bedside as nursing is expected to witness the resident taking her medications. The clinical record for Resident S was reviewed on 5/13/21 at 9:57 a.m. Resident S's diagnoses included, but not limited to, major depressive disorder, muscle weakness, dysphagia (swallowing issue), diabetes, borderline personality disorder, and anxiety. The clinical record contained a quarterly Evaluation for Self-Administration of a Procedure dated 12/15/20 for Resident S. The		determined to be appropriate to take medications once delivered by the staff at own pace. An order has been obtained and the plan of care revised that staff may leave medication cup at bedside with resident and resident may take after the meal. 2. All residents have the potential to be affected. Will review with staff to determine if there are other residents who may wish to do the same and follow the policy accordingly. 3. The Medication Self-Administration policy was reviewed and no changes are indicated. Staff will be educated on the Self-Administration policy to ensure those with orders will be allowed to self-administer as ordered only. The DON or her designee will round 5 times weekly to ensure only those ordered to self-administer are doing so for 4 weeks and until 100% compliance is achieved, then 5 times per month for 6 months and until 100% compliance is maintained. 4. The findings of the audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	05/19/2021

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

(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
	evaluation for self-administration of insulin indicated the IDT recommendation was "the resident may self-administer the procedure with oversight". Resident S's clinical record did not contain a self-administration evaluation for any other medications. A Self-Administration of Medication policy was received from DON (Director of Nursing) on 5/17/21 at 10:32 a.m. The policy indicated, "1. It is the responsibility of the interdisciplinary team (IDT) to determine if a resident requesting to self-administer medication(s) is safe before the resident exercises that right. A resident may only self-administer medication(s) after the IDT has determined which medication(s) may be self-administered...3. Appropriate documentation of IDT determinations MUST be in the resident medical record and care plan. 4. Residents self-administering medication(s) should have documentation of training in the proper manner of self-administration, completed by a licensed nurse and/or pharmacist or according to facility policy...." 3.1-11(a)			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure a resident's call light was within reach for 1 of 1 resident	F 0558	1. Resident B was not harmed and her call light was placed within reach upon notification. 2. All residents have the potential	06/18/2021

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	05/19/2021

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

(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
	reviewed for accommodation of needs. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/11/21 at 3:00 p.m. The diagnoses for Resident B included, but were not limited to, hemiplegia and hemiparesis. The 3/26/21 Quarterly MDS (Minimum Data Set) assessment indicated locomotion on and off the unit occurred only once or twice during the assessment period, requiring 1-person physical assistance. She required extensive assistance of one person for bed mobility and was totally dependent on 2 persons for transfers. An observation and interview was conducted with Resident B on 5/11/21 at 3:22 p.m. She was lying in bed. Her call light was out of reach, wrapped around her bed frame near the top of her mattress. Resident B indicated she could not reach her call light. An observation of Resident B was made on 5/18/21 at 4:15 p.m. She was sitting in her wheelchair, 4 feet from her bed. Her call light was out of reach, resting in the middle of her bed. An observation of Resident B was made on 5/19/21 at 10:43 a.m. She was sitting in her wheelchair between the bed and the door near the front of room. Her call light was out of reach, resting on the bed. An observation of Resident B was made on 5/19/21 at 10:44 a.m. She was still sitting in her wheelchair in her room with her call light out of		to be harmed and rounds were made at that time to ensure all call lights were within reach. 3. The Call Light policy was reviewed and no revisions are indicated. Staff will be educated on this policy. The DON or her designee will make rounds on random units at varying times at least 5 times weekly to include weekends, ensuring call lights are within reach, for 4 weeks and until 100% compliance is achieved, then monthly for 6 months and until 100% compliance is maintained. 4. Findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	05/19/2021

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

(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
	reach. QMA (Qualified Medication Aide) 14 entered the room and assisted Resident B in her wheelchair from the front of the room to over by the window, as she was expecting a visitor for her. QMA 14 did not give Resident B her call light, and it remained on the bed when QMA 14 left the room. An observation of Resident B was made on 5/19/21 at 11:08 a.m. She was still sitting in her wheelchair by the window. Her call light remained on the bed, out of reach. The Call Light policy was provided by the Nurse Consultant on 5/19/21 at 11:43 a.m. It read, "The call light should be within reach of the resident whether in bed, sitting in a chair in their room, in the toilet and bathing areas. The intent of this requirement is that residents, when in their rooms, toilet and bathing areas, have a means of directly contacting caregivers." 3.1-3(v)(1)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions			

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	05/19/2021

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

(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
	of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview, and record review, the facility failed to assist a resident with getting up in the morning at her preferred time and ensure a resident's preference with bathing time was honored for 2 of 8 residents reviewed for activities of daily living. (Resident H and Resident J) Findings include: 1. The clinical record for Resident H was reviewed on 5/12/21 at 11:00 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis. The 3/26/21 Quarterly MDS (Minimum Data Set) assessment indicated she was cognitively intact and totally dependent on staff for dressing and transfers. The ADL (activities of daily living) care plan, revised 12/2/20, indicated she needed assistance	F 0561	1. No residents were harmed. See below for corrective actions. 2. All residents have the potential to be affected. Resident preferences will be reviewed to ensure scheduled and care planned appropriately. 3. The Resident Choices policy was reviewed and no revisions are indicated. The staff will be educated on this policy. The Social Services Director or her designee will interview 5 residents per week for 4 weeks and until 100% compliance is achieved to ensure preferences are honored, then 5 residents per month for 6 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented at the facility's monthly QAPI meetings and the plan of actions adjusted	06/18/2021

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	05/19/2021

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

(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
	with bed mobility, transferring, toileting, bathing, dressing, grooming, and eating and required a Hoyer lift for transfers with the assistance of 2 staff members. The choices care plan, revised 1/13/21, indicated she had no preference of what time she got up in the morning. An interview was conducted with Resident H on 5/12/21 at 11:04 a.m. She indicated the time staff assisted her out of bed on a daily basis varied, and there were times they did not assist her up for the day at all. An interview and observation was conducted with Resident H on 5/13/21 at 11:45 a.m. She was up, dressed, and in her wheelchair. She indicated staff had just gotten her up, but would like to be up by at least 10:00 a.m., and her choices care plan did not accurately reflect her preferred wake up time. An interview and observation of Resident H was conducted on 5/14/21 at 10:53 a.m. She was awake, still lying in bed. She indicated staff had not yet come in to assist her with getting up, and she did not feel good about still being in bed at this time. An observation of Resident H was made on 5/17/21 at 11:05 a.m. She was awake, still lying in bed. An observation of Resident H was made on 5/18/21 at 11:10 a.m. She was awake, still lying in bed. An interview and observation was conducted with Resident H on 5/18/21 at 4:20 p.m. She was up,		accordingly.	

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	05/19/2021

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

(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
	dressed, and in her wheelchair. She indicated staff started assisting her to get up on 5/17/21 at 12:00 p.m., but the aide had to assist with the lunch service, and never came back, so she ended up staying in bed all day. Today, they didn't assist her with getting up until 2:00 p.m., so she missed her 1:30 p.m. hair appointment. She indicated she was highly upset about not getting up at all on 5/17/21 and missing her hair appointment today. An interview and observation was conducted with Resident H on 5/19/21 at 10:56 a.m. She was awake, lying in bed. She indicated no one had yet come to assist her with getting up for the day. On 5/19/21 at 11:02 a.m., while Resident H was still lying awake in bed, an interview was conducted with CNA (Certified Nursing Assistant) 9, who was assigned to Resident 9. She indicated she was unaware of Resident H's preferred get up time and had never worked with her before today. The CNA assignment sheet for Resident H's hall was provided by LPN (Licensed Practical Nurse) 10 on 5/19/21 at 11:12 a.m. It did not reference Resident H's or any other resident's preferred wake up time. The Resident Choices policy was provided by UM (Unit Manager) 20 on 5/17/21 at 3:05 p.m. It read, "The facility will honor the specific resident choices such as: Time to get up in the morning." 2. The clinical record for Resident J was reviewed on 5/19/21 at 12:00 p.m. The diagnosis included, but was not limited to: convulsions. An Admission Minimum Data Set (MDS) dated			

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	05/19/2021

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

(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
	3/10/21, indicated Resident J was cognitively intact. A care plan dated 3/4/21 for Resident J indicated "...I have specific choices...I prefer to have bed baths and will receive them two times per week before breakfast on facility scheduled days..." An ADL's care plan dated 3/16/21 indicated "...I need assistance with ADLs related to activity intolerance, pain, and debility. I need limited to total assist with most aspects of ADLs. I can use my upper extremities...Interventions...Allow me choices when care is to be done and respect my wishes..." An interview was conducted with Resident J on 5/19/21 at 9:27 a.m. He indicated he had not received his bed bath yesterday. He was supposed to receive 2 bed baths a week. The days vary week to week, so the staff are not consistent with the same days he gets them. The staff provide them in the evenings. He recalls on admission the staff asking what his preference was for bathing, and he chose mornings. He does not like to receive bed baths at night. He preferred in the mornings. A shower schedule was provided by the Director of Nursing on 5/13/21 at 4:00 p.m. It indicated Resident J was to receive bathing on Tuesday and Friday evenings. An interview was conducted with Certified Nursing Aide (CNA) 1 on 5/19/21 at 9:37 a.m. She indicated she had not provided a bed bath to Resident J this morning. She was unsure if Resident J had received one yesterday evening. The staff will provide bathing as preferred.			

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	05/19/2021

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

(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
	A "Resident Choices" policy was provided by Unit Manager 20 on 5/17/21 at 3:05 p.m. It indicated "...Purpose: To ensure that resident choices are honored in regards to provided center care...Procedure: 1. An interview with the resident/resident representative will be conducted on the next business day after admission by a member of the clinical team. The facility will determine who will be responsible for completing the interview...3. The questions will allow the resident to choose times and situations that are acceptable to them. 4. The facility will honor the specific resident choices such as: ...Type, frequency and day(s) of bathing...." 3.1-3(u)(1) 3.1-3(u)(3)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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.			

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	05/19/2021

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

(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
	Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 2 residents reviewed for abuse. (Resident W) Findings include: The clinical record for Resident W was reviewed on 5/12/21 at 12:20 p.m. The diagnosis included, but was not limited to: chronic pain. An Admission Minimum Data Set (MDS) dated 5/11/21, indicated Resident W was cognitively intact. An interview was conducted with Resident W on 5/12/21 at 12:27 p.m. She indicated the night nurse she had on 5/11/21, would not give her any pain medication. She feels he was verbally abusive. The completed investigation file for Resident W was provided by the Nurse Consultant on 5/18/21 at 3:00 p.m. The Nurse Consultant indicated at that time the investigation was completed. The following was included in the completed investigation file: 1. An incident was reported on 5/12/21 to the Indiana Department of Health. The follow up indicated "...5/16/21 The investigation has concluded. Unable to substantiate resident's allegations. Staff was allowed to return to work and social services will continue to monitor the resident for potential adverse effects..." 2. A statement by Resident W indicated	F 0610	1. Social services is following up with resident W to ensure no signs of mental anguish. 2. All residents have the potential to be affected. See corrective measures below. 3. The Abuse policy and procedure was reviewed and no revisions are indicated. Administrative staff (HFA, DON, ADON, SSD, SSA) will be educated on this policy. The Regional Director of Operations or his designee will review all abuse allegation investigations prior to any staff returning to work post suspension as a result of the allegation for 3 months and until 100% compliance is achieved, then conduct monthly reviews for 6 months to ensure continued compliance. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/18/2021

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	05/19/2021

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

(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
	"...resident states she went to nurse's station last evening and told the nurse she was in pain; she felt the nurse did not listen and did 'nothing'. When asked if nurse yelled, she stated 'I didn't like his tone!'..." 3. Interviews were conducted with Residents BB, CC, DD, FF. 4. A statement from License Practical Nurse (LPN) 30. The statement dated 5/13/21 by LPN 30 indicated "...Resident came to the nurse's station and requested to have her PRN [as needed] medication for pain. Writer checked the MAR [Medication Administration Record] and noted that resident had received oxycodone for pain at 22:25 [10:25 p.m.] hours. As per prescription, the medication is due every 12 hrs. [hours]. Writer explained to resident that she had received pain medication approximately 2 hours ago and that she should rest in bed and allow the medication to work in her system. Resident became upset and stated that she been taking the medication at home any time she needed it. Resident returned to her room and made no further request for pain medication until end of shift..." The file did not include other staff interviews that worked on the unit with LPN 30 on the night of 5/11/21. The 5/11/21 staff worked schedule indicated Certified Nursing Assistant (CNA) 32 and CNA 33 had worked on the unit with LPN 30 on the night of 5/11/21. An interview was conducted with the Nurse			

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	05/19/2021

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

(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
	Consultant on 5/19/21 at 2:30 p.m. She indicated other staff had been verbally interviewed about the incident. They were putting their statements in writing. Three staff statements were provided by the Nurse Consultant on 5/19/21 at 2:30 p.m. The statements were written by LPN 3, LPN 2, Qualified Medication Aide (QMA) 13. They stated the following: The statement written by LPN 3 dated 5/19/21 indicated "I, [LPN 3] worked on 5/12/21 from 7am [7:00 a.m.] to 1530 [3:30 p.m.], No concerns or allegations was made from [Resident W] concerning night shift nursing staff..." The statement written by LPN 2 dated 5/19/21 indicated "I [LPN 2] worked on 5/12/21 from 7:00 am (sic) to 3:30 pm, (sic) no concerns or allegations was made from [Resident W] concerning night shift nursing staff..." The statement written by QMA 13 no date indicated "I, QMA 13 worked 5/12/21 6:30 am [a.m.] 3pm [3:00 p.m.] I didn't hear any concerns about night shift staff from [Resident W] no concern was made to me..." An interview was conducted with the Nurse Consultant, Executive Director and Director of Nursing on 5/19/21 at 3:15 p.m. The Executive Director indicated they were trying to reach CNA 32 and CNA 33. This Federal Tag relates to complaints IN00351254, IN00351434 and IN00353741. 3.1-28(d)			

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	05/19/2021

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

(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 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and			

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	05/19/2021

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

(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
	any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on interview and record, the facility failed to develop a pain care plan with person centered approaches for 2 of 5 residents reviewed for pain and 1 of 2 residents reviewed for communication (Resident D, L and Q) Findings include: 1. The clinical record for Resident D was reviewed on 5/12/21 at 10:00 a.m. The diagnoses included but were not limited to: mixed receptive-expressive language disorder, aphasia, hemiplegia, and hemiparesis. The 4/30/21 Quarterly MDS (Minimum Data Set) assessment indicated Resident H had pain in the past 5 days, occasionally, with a pain intensity of 5 on a 1 through 10 pain level scale. There was no pain care plan in Resident D's clinical record. On 5/14/21 at 3:20 p.m., an interview was conducted with the MDS Coordinator, who conducted the pain assessment for the 4/30/21 Quarterly MDS assessment. She indicated Resident D should have a pain care plan since that was something new for her. The MDS Coordinator reviewed Resident D's care plans and indicated, "I don't see one. We'll put one in for her." 2. The clinical record for Resident L was	F 0656	1. Residents D, L and Q were reviewed, reassessed as indicated, and care plans reviewed/revised where needed. 2. All residents have the potential to be affected. All comprehensive care plans will be reviewed and revised as indicated. 3. The Care Planning policy was reviewed and no revisions are indicated. The IDT members will be educated on this policy. The DON or her designee will review 5 comprehensive care plans weekly for 4 weeks to ensure all problems are addressed and appropriate interventions are in place. This will continue for 4 weeks and until 100% compliance is achieved then 5 per month for 6 months to ensure compliance is maintained. 4. The findings of these audits will bee reviewed during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/18/2021

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	05/19/2021

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

(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
	reviewed on 5/18/21 at 11:30 a.m. The diagnoses included, but were not limited to: heart failure, stroke, cardiac arrest, acute respiratory failure and chronic kidney disease. Resident L was admitted to the facility on 4/24/21. An Admission Minimum Data Set (MDS) dated 5/1/21, indicated Resident L was moderately cognitively impaired. A Physical Therapy Evaluation dated 4/26/21 indicated on pain assessment "...patient states she is having pain that has been going on for a while. Patient did demonstrate pain behaviors when palpating R [right] calf...Patient winces/grimes with any movement of RLE [right lower extremity]...behaviors exhibited: moaning, grunting, facial grimacing and tense with any passive movement to RLE..." A physician order dated 4/29/21 indicated Resident L was to receive 50 milligrams of tramadol twice a day for pain. A Narcotic Count Sheet for Resident L indicated she had received tramadol twice a day on 5/5/21, 5/6/21, and 5/7/21. She had received the pain medication once a day on 5/8/21. A skin care plan dated 5/3/21 indicated "I have skin failure (bruise) related to recent fall to my R foot, 1st digit [toe]...Goal I will state my pain is managed with my care plan interventions..." The clinical record did not include a care plan with interventions in place to address her pain. An interview was conducted with Case Manager 8 on 5/18/21 at 9:37 a.m. She indicated when			

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	05/19/2021

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

(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
	Resident L started experiencing pain it should have been communicated with the MDS Coordinator to create a care plan addressing her pain. A "Care Planning" policy dated 3/20/21 was provided by the Unit Manager 20 on 5/17/21 at 3:05 p.m. It indicated "...Policy: It is the policy of this facility to develop a comprehensive plan of care that is individualized, and reflective of the resident's goals, preferences, and services that are to be provided to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being....18. The comprehensive care plan will be updated with any changes in the resident's orders, care or services that change the plan of care..." 3. The clinical record for Resident Q was reviewed on 5/11/21 at 12:36 p.m. The Resident's diagnosis includes, but are not limited to, cognitive communication disorder and diabetes. The clinical record contained an Annual MDS (Minimum Data Set) Assessment, completed 2/17/21, which indicated he was cognitively intact and had minimal hearing deficit. He was not wearing a hearing aid during the assessment. He was able to make his needs known and able to understand others. The CAA (Care Area Assessment), completed 2/23/21, indicated that a care plan would be developed for communication to avoid complications and to maintain his current communication level. During an interview on 5/11/21 at 12:36 p.m., Resident Q indicated he had difficulty hearing and was supposed to wear hearing aids. His			

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	05/19/2021

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

(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
	hearing aides had been missing for a while. He was observed asking that questions be repeated so that he could hear what was said. During an interview on 5/19/21 at 11:40 a.m., he indicated that he had an appointment to see the audiologist to receive new hearing aids. The clinical record did not contain a care plan addressing his hearing deficit or communication abilities. During an interview on 05/18/21 at 2:14 p.m., the Nurse Consultant indicated that a communication care plan should have been completed. The Pain Evaluation policy was provided by the ADON (Assistant Director of Nursing) on 5/14/21 at 12:10 p.m. It read, "Residents will have a pain evaluation completed upon admission, quarterly, and when the resident experiences new pain in a different location...The resident will have a care plan developed for their pain control with established interventions, and this will be reviewed on a quarterly basis and as needed with change." On 5/17/21 at 3:05 p.m., UM (Unit Manager) 4 provided the Care Plan Policy, revised March 2020, which read "...It is the policy of this facility to develop a comprehensive plan of care that is individualized, and reflective of the resident's goals, preferences, and services that are to be provided to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being...8. The comprehensive care plan will include a summary of the assessment of the Residents'...f. MDS findings..."			

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	05/19/2021

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

(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
	This Federal Tag relates to complaints IN00351434 and IN00353741. 3.1-35(a) 3.1-35 (b)(1)			
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 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 interview and record review, the facility failed to have and invite a resident to a care plan meeting for 2 of 3 residents reviewed	F 0657	1. Residents H and T were not harmed. A care plan conference will be scheduled and each will be	06/18/2021

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	05/19/2021

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

(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
	for care plan invitation. (Resident H and T) Findings include: 1. The clinical record for Resident H was reviewed on 5/12/21 at 11:00 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis. The 3/26/21 Quarterly MDS (Minimum Data Set) assessment indicated she was cognitively intact. An interview was conducted with Resident H on 5/12/21 at 11:14 a.m. She indicated she was not invited to her care plan meetings and would like to attend. The clinical record indicated she had MDS assessments completed on the following dates: 12/8/20, 12/24/20, and 3/26/21. An interview was conducted with the SSD (Social Services Director) on 5/13/21 at 3:15 p.m. She indicated care plan meetings were scheduled to coincide with MDS assessments. For residents who were cognitively intact and able to participate, the meetings would be held in their rooms, and verification of the meeting was documented as a Multidisciplinary Care Conference Summary under the assessments tab of the electronic health record. Resident H should have had a meeting that coincided with her 3/26/21 Quarterly MDS assessment. The SSD looked in a binder and found an invitation to Resident H's family for a care plan meeting to be held on 4/14/21. The SSD reviewed Resident H's progress notes and assessments and indicated she didn't see verification the 4/14/21 care plan		invited. 2. All residents have the potential to be affected. An audit will be conducted and any resident without proof an invite will be identified, a care plan conference scheduled, and the resident invited to attend. 3. The Care Plan Meeting and Invitation policy was reviewed and no revisions are indicated at this time. Social Services staff will be educated on the policy. The Administrator or his designee will audit 5 residents per week for 4 weeks and until 100% compliance is achieved then 5 residents per month for 6 months and until 100% compliance is maintained to ensure residents are being invited. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	05/19/2021

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

(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
	meeting took place, and her last documented care plan meeting was 12/2/20. Resident H's clinical record, including progress notes and assessments, did not reference a care plan meeting after 12/2/20. 2. The clinical record for Resident T was reviewed on 5/13/21 at 3:47 p.m. Resident T's diagnoses included, but not limited to, diabetes type II, hypertension, congestive heart failure, lymphedema, and anxiety disorder. A Quarterly Minimum Data Set (MDS) dated 4/28/21 indicated, Resident T was cognitively intact and was able to make daily decisions regarding her care. An interview with Resident T was conducted on 5/12/21 at 12:16 p.m. She indicated, she was interested in attending her care plan meetings, but had not been invited to one in a while. An interview with SSD (Social Services Director) was conducted on 5/13/21 at 3:42 p.m. SSD indicated; care planning meetings are to be done at least quarterly. The last care plan meeting for Resident T was on 1/29/21. SSD stated, Resident T is overdue for her care plan meeting nor had it been scheduled as of this date. The SSD provided the Care Plan Meeting and Invitations policy on 5/14/21 at 10:36 a.m. It read, "It is the policy of this facility to invite residents and/or Resident Representative(s) to resident care plan meetings." 3.1-35(c)(2)(C) 3.1-35(d)(2)(B)			

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	05/19/2021

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

(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 0675 SS=D Bldg. 00	483.24 Quality of Life § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure a resident's communication tools were accessible to her for 1 of 1 resident reviewed for communication. (Resident D) Findings include: The clinical record for Resident D was reviewed on 5/12/21 at 10:00 a.m. The diagnoses included, but were not limited to: mixed receptive-expressive language disorder, aphasia, hemiplegia, and hemiparesis. She was admitted to the facility on 11/1/20. The 4/30/21 Quarterly MDS (Minimum Data Set) assessment indicated Resident H's speech clarity was unclear with slurred or mumbled words. She sometimes had the ability to make herself understood and to understand others, as she responded adequately to simple, direct communication only. The 12/15/20 Speech Therapy Functional Maintenance Program indicated she had severe expressive aphasia and comprehension deficits. Use of communication boards were not 100%	F 0675	1. Resident D was not harmed. The Communication book and board were placed within reach of the resident. 2. All residents with communication devices have the potential to be affected. An audit will be conducted to ensure that all residents with devices are identified and all devices are kept within reach. 3. Staff will be educated on Resident Rights. The DON or her designee will round on all residents with communication devices twice weekly for 4 weeks and until 100% compliance is achieved to ensure devices are easily accessible, then monthly for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/18/2021

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	05/19/2021

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

(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
	successful but improved her functional communication. Recommendations were for staff to encourage use of communication boards in her room and have the boards accessible to her. Resident D's 4/20/21 and 11/13/20 aphasia care plans did not reference her use of a communication board or book. An interview was conducted with Family Member 21 on 5/17/21 at 1:30 p.m. She indicated there should be a communication board that she uses, but she never really saw one available for her. She and the rest of her family created a book for her to use, but the facility informed her there would be a specific tool created by them for her to use as well. An interview and observation was conducted with Resident D on 5/12/21 at 10:10 a.m. in her room while she was lying in bed. Communication with Resident D was difficult, due to her diagnoses, and there was no communication board available for use. During this observation, LPN (Licensed Practical Nurse) 10 entered the room and began communicating with Resident D. After several minutes, Resident D began pointing to the bookshelf. LPN 10 opened a door to the shelf and retrieved the communication book created by Resident D's family, which assisted her in communicating with Resident D. This book was not readily accessible to Resident D. An interview was conducted with CNA (Certified Nursing Assistant) 23 on 5/17/21 at 2:19 p.m. She indicated she worked with Resident D previously and she would just point to what she wanted. If she didn't understand her, she would retrieve other staff to assist her with			

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	05/19/2021

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

(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
	communication. CNA 23 was unaware of a communication board available for communicating with Resident D. An interview was conducted with LPN 10 on 5/17/21 at 2:20 p.m. She indicated she hadn't seen a communication board in Resident D's room, but she was aware of the book used with her during the interview and observation on 5/12/21 at 10:10 a.m. An observation of Resident B's room was made with the Wound Nurse on 5/17/21 at 2:30 p.m. for the purpose of reviewing her communication boards. Resident B was not present at this time. The communication book created by family was located in the bookcase and reviewed. There was no other communication tool located or reviewed. An observation was conducted on 5/17/21 at 3:24 p.m. Resident D was in her wheelchair in her room. The communication book created by family was on a bookshelf behind a case of water. There was no other communication tool accessible to Resident D at this time. An interview was conducted with SLP (Speech Language Therapist) 24 on 5/18/21 at 10:42 a.m. She indicated she worked with Resident D in December 2020, at which time she had 2 communication tools available for use, the book her family created for her and another one with pictures of toileting, brushing teeth, and other basic needs. She expected for both tools to be accessible to Resident D. The Residents Rights policy was provided by the Nurse Consultant on 5/19/21 at 2:02 p.m. It read, "Living Accommodations and			

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	05/19/2021

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

(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
	Care...Services necessary to attain or maintain your highest practicable level of functioning." 3.1-37(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review the facility failed to provide showers as scheduled, nail care, shampooing of hair and shaving for 3 of 8 resident's reviewed for ADL care (Resident O, J, and P) Findings include: 1. The clinical record for Resident O was reviewed on 5/12/21 at 2:24 p.m. The Resident's diagnosis included, but were not limited to, dementia and mood disorder. The clinical record contained an Annual MDS (Minimum Data Set) Assessment, complete 3/3/21, which indicated she was severely cognitively impaired. She required extensive assistance with personal hygiene and total assistance with bathing. During an observation on 5/12/21 at 2:24 p.m., she was observed sitting in her wheelchair in the hallway. The fingernails on her right hand were extending past the tips of her fingers and had a dark substance under them. During on observation on 5/18/21 at 9:40 a.m.,	F 0677	1. Residents O, P, and J were provided needed ADL care as the facility was notified of the concerns. 2. All residents have the potential to be affected. Rounds completed to ensure residents received ADL care as needed/scheduled. 3. The Personal Hygiene policy was reviewed. No revisions are indicated and the staff will be educated on this policy. The DON or her designee will check 10 random residents to ensure necessary ADL care has been performed performed. Audits will continue weekly for 4 weeks and until 100% compliance is achieved, then 10 residents per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented at the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/18/2021

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	05/19/2021

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

(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
	she was observed sitting in her wheelchair in the hallway. The fingernails on both of her hands were extending past the tips of her fingers and had a dark substance under them. During an interview on 5/18/21 at 9:41 a.m., CNA (Certified Nursing Assistant) 27 indicated she often cared for Resident O and that due to her dementia she had a hard time taking care of her own nails. She would try to take care of them, but then become frustrated when she was unable to complete the task. CNA 27 would try to cut and file her fingernails for her as they were long. During an observation on 5/19/21 at 11:05 a.m., Resident O was sitting in the common area of the unit. Her nails on her right hand were extending past the tips of her fingers and had a dark substance under them. 2. The clinical record for Resident P was reviewed on 5/12/21 at 9:59 a.m. The Resident's diagnosis included, but were not limited to, weakness and hypertension. The clinical record contained an Annual MDS (Minimum Data Set) Assessment, completed 3/12/21, which indicated she was cognitively intact and required total assistance with showers or full body bathing. A care plan, revised 1/19/21, indicated she had specific choices and would like to receive showers 2 times weekly. During an interview on 5/12/21 at 9:59 a.m., she indicated that she had not been offered a shower for 2 weeks. She was to get a shower on Monday			

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	05/19/2021

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

(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
	and Thursday each week. The DON (Director of Nursing) provided the shower schedule on 5/13/21 at 4 p.m. It indicated she was to receive showers on Monday and Thursday evenings weekly. During an interview on 5/18/21 at 9:35 a.m., Resident P indicated she had not received a shower on 5/13/21 or 5/17/21. On 5/18/21 at 2:03 p.m., the April and May 2021 shower and shampoo documentation for Resident P was provided by the Nurse Consultant. It indicated she had received a bed bath on the following days, 4/1, 4/4, 4/5, 4/8, 4/9, 4/11, 4/12, 4/18, 4/19, 4/25, 4/26, 4/29, 5/2, 5/3, 5/6, 5/7, 5/13, 5/15, 5/16, and 5/17. There was no documentation present that she had received a shower in April or May 2021. 3. The clinical record for Resident J was reviewed on 5/19/21 at 12:00 p.m. The diagnosis included, but was not limited to: convulsions. An Admission Minimum Data Set (MDS) dated 3/10/21, indicated Resident J was cognitively intact. The resident needed total assistance with bathing with 2 staff persons. A care plan dated 3/4/21 for Resident J indicated "...I have specific choices...I prefer to have bed baths and will receive them two times per week before breakfast on facility scheduled days. An ADL's care plan dated 3/16/21 indicated "...I need assistance with ADLs related to activity intolerance, pain, and debility. I need limited to total assist with most aspects of ADLs. I can use			

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	05/19/2021

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

(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
	my upper extremities...Interventions...Allow me choices when care is to be done and respect my wishes..." A shower schedule was provided by the Director of Nursing on 5/13/21 at 4:00 p.m. It indicated Resident J was to receive bathing on Tuesday and Friday evenings. An observation of Resident J on Tuesday, 5/11/21 at 1:14 p.m. Resident J was observed scratching his head. He indicated he receives what the facility referred to as a bed bath. The staff rub a piece cloth over his skin. He never gets his hair washed. The resident stated his hair was so "dry" and "itchy" due to lack of shampooing. He was afraid his hair would "break off". An observation was made of Resident J on Tuesday 5/18/21 at 2:49 p.m. The resident was observed in bed scratching his head and gray stubbled facial hair was on his checks and chin. He indicated he had not received his hair washed or shaved. An observation was made of Resident J on Wednesday, 5/19/21 at 9:27 a.m. Resident J was observed in bed. The resident had gray facial hair on his chin and cheeks. He indicated he had not received his bed bath yesterday. He was supposed to receive 2 bed baths a week. The days vary week to week, so the staff are not consistent with the same days he receives them. He had not had his hair washed, since he had been in the facility. The staff are also not shaving him. He has asked both days and evening shift staff to do it. They all say the same thing, "We will get to you when we can." They never come back. If his facial hair was to be overgrown the razors at the facility are			

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	05/19/2021

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

(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
	cheap and are unable to cut through his facial hair. His hair on his head was so "dry" and "itchy" due to not be washed. An interview was conducted with Certified Nursing Aide (CNA) 1 on 5/19/21 at 9:37 a.m. She indicated she had not provided a bed bath to Resident J that morning and was unsure if Resident J had received one yesterday evening per the shower scheduled time. Bed baths consist of bathing the resident, shaving and linen changes. The residents can have their hair washed at their request using a basin of water and shampoo while in bed. A "Personal Hygiene" policy was provided by the Unit Manager 20 on 5/17/21 at 3:05 p.m. It indicated "...Purpose: To ensure residents receive necessary care and assistance for personal hygiene tasks...Policy: 1. Personal hygiene will be performed 2 times daily in the morning and before bed. 2. Residents will be offered a shower/full bath at a minimum of 2 times a week. resident preferences will be honored...3. Nail care will be provided as needed. Diabetic nail care must be performed by a licensed nurse or podiatrist. 4. Personal hygiene may include, but is not limited to: ...g. shaving..." This Federal Tag relates to complaints IN00351254, IN00351434, and IN00353741. 3.1-38(a)(3)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the			

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	05/19/2021

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

(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
	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to monitor a resident's toe as ordered and obtain a venous Doppler ultrasound timely that resulted in a hospitalization with the need for surgical intervention for a necrotic toe for 1 of 2 residents reviewed for hospitalization, provide a wound dressing as ordered for 1 of 2 residents reviewed for wounds, and ensure a resident received care in accordance with physician's orders to monitor weight daily and notify a physician of weight changes based on the physician's orders for 1 of 1 resident reviewed for nutrition. (Resident L, Resident N and Resident T) Findings include: 1. The clinical record for Resident L was reviewed on 5/18/21 at 11:30 a.m. The diagnoses included, but were not limited to: heart failure, stroke, cardiac arrest, acute respiratory failure and chronic kidney disease. Resident L was admitted to the facility on 4/24/21 and discharged to hospital on 5/8/21. An Admission Minimum Data Set (MDS) dated 5/1/21, indicated Resident L was moderately cognitively impaired. The resident needed extensive assistance of 2 persons for bed mobility, transfers and total assistance with bathing, dressing and toileting of 1 person. A skin care plan for Resident L dated 5/3/21	F 0684	1. Resident N's dressing change was completed upon notification. Resident T's MD was notified of weight gain and weight refusals. Resident L no longer resides at the facility. 2. All residents have the potential to be affected. Residents with wounds were checked to ensure wound dressings were intact. Residents with ordered weights with paraments were checked to ensure MD notification is documented. Lab and diagnostic orders were checked to ensure they were scheduled/completed. 3. The policies for Following Medication-Physician Orders/Parameters and Medical Records Documentation procedure and guidelines were reviewed and no revisions necessary. Staff will be educated on these policies. The DON or her designee will audit 10 new orders weekly to ensure there is appropriate follow-up, review 10 resident's wound dressings weekly to ensure they are in place and audit 10 residents with routine weights and parameters orders weekly to ensure order is followed, each for 4 weeks and until 100% compliance is	06/18/2021

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	05/19/2021

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

(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
	indicated "I have skin failure (bruise) related to recent fall to my R foot, 1st digit [toe]...Goal I will state my pain is managed with my care plan interventions...Monitor area and notify MD [medical doctor] with any changes noted." During a confidential interview on 5/14/21 at 3:25 p.m., she indicated the nursing staff did not closely monitor or address Resident L's toe timely. They diagnosed her toe as bruised from a fall. Then the resident was days later sent to the hospital and now have toes that are necrotic and gangrene. A Physical Therapy Evaluation dated 4/26/21 indicated on pain assessment "...patient states she is having pain that has been going on for a while. Patient did demonstrate pain behaviors when palpating R [right] calf...Patient winces/grimes with any movement of RLE [right lower extremity]...behaviors exhibited: moaning, grunting, facial grimacing and tense with any passive movement to RLE..." A nursing note dated 4/27/21 indicated Resident L had an unwitnessed fall on this day. Resident L was found on floor of room. "...Can move upper and lower extremities within normal limits. Alert and oriented x2 [times 2] with slight confusion. Pain in right lower extremity on a scale 3 out of 10 but states pain was present before the fall..." A physician progress note for Resident L dated 4/29/21 indicated "...Today, she is endorsing right leg pain, it is in the posterior calf, localized, sharp, hypersensitive to minimal touch, it is fairly constant throughout the day. She denies any significant relief for it. She has no pain medication at this point. She denies any other relief....Her pain does get worse with		achieved. Above audits will then be completed at a rate of 10 per month for 6 months and 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	05/19/2021

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

(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
	walking....pain...tramadol 50 mg (milligrams) 2x [twice] a day...2. Deconditioning/Gait Instability - Patient is high risk for functional impairment without therapy and adequate pain control. Patient has high risk for developing contractures, pressure ulcers poor healing or fall if not receiving adequate therapy and pain control...7. Right lower calf pain hypersensitive. Recommend a Doppler to rule out blood clot..." A physician order dated 4/29/21 indicated Resident L was to have a venous Doppler ultrasound on right lower leg. There was no indication in the health record that this was completed. A nursing note dated 4/30/21 indicated Resident L had an unwitnessed fall on this day. Resident L was found on the floor of room. Staff assessed and no injury noted. An initial skin report dated 5/2/21 indicated Resident L had a bruise on her right great toe. The skin appearance was purple. The resident denied pain. A nursing progress note dated 5/3/21 indicated Resident L had a purple bruise on her right foot big toe. Resident L had no complaints of pain, and it appeared to be from a fall. A physician note dated 5/3/21 indicated Resident L was being seen for pain in her right big toe. "...Musculoskeletal: Extremities no lower leg edema. Right big toe cold, erythema [redness], tender to touch, weak pulse...6. Great toe pain, right. Suspect ischemia [reduction in blood flow] will have vascular see her today per her follow up..."			

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	05/19/2021

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

(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
	A nursing progress note written by License Practical Nurse (LPN) 3 dated 5/3/21 indicated "...MD [medical doctor] saw right big toe this am [a.m.] No new orders. Resident to go see vascular today. Will see if they recommend anything new for resident. Will continue to monitor resident closely." An "After Visit Summary" from heart and vascular clinic dated 5/3/21 at 10:30 a.m., did not include documentation the toe had been assessed by the clinic. There was no documentation in Resident L's clinical record the nursing staff clarified with the clinic Resident L's toe was assessed on the 5/3/21 follow up appointment. An interview was conducted with Nurse Practitioner (NP) 7 at the cardiac/vascular clinic on 5/17/21 at 10:25 a.m. She indicated Resident L was seen by her on 5/3/21 for a follow up visit due to the resident's hospitalization after a cardiac event a few weeks ago. NP 7 was unaware Resident L's great toe needed to be looked at due to possibly ischemic. The resident was in a wheelchair during her appointment. She had assessed her pulses but had not removed her socks. Resident L's feet were not observed at the appointment, and she had no complaints of pain during the visit. NP 7 indicated she would have "absolutely" wanted to be informed about the ischemic toe. She would have referred her to be looked at by the vascular team. A physician order 5/3/21 indicated staff was to "monitor bruised area to R [right] foot, 1st digit [big toe], notify MD/NP [medical provider or nurse practitioner] with any changes noted...every shift for impaired skin integrity."			

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	05/19/2021

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

(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

The May 2021 Treatment Administration Record (TAR) indicated the nursing staff was placing a check mark on the electronic TAR indicating Resident L's bruised toe was monitored for changes every shift on the following days and shifts:

5/3/21 - night shift
5/4/21 - day, evening and night shifts,
5/5/21 - day, evening, and night shifts,
5/6/21 - day, evening, and night shifts,
5/7/21 - day, evening, and night shifts,
5/8/21 - day shift.

An interview was conducted with LPN 3 on 5/17/21 at 4:15 p.m. She indicated on the morning of 5/3/21, Physician 35 had come in to see Resident L, and he recommended to notify the vascular clinic to look at Resident L's toe at her appointment that day due to possibly ischemic. She was unsure if the clinic was notified. She had not notified the clinic. LPN 3 had seen Resident L's toe on 5/2/21, when it was a small bruise, but had never seen her toe after that day. She had signed off on Resident L's TAR she had monitored Resident L's bruised toe on Thursday, 5/6/21, day and evening shift, and Friday, 5/7/21, on day shift.

An interview was conducted with LPN 2 on 5/18/21 at 9:50 a.m. She indicated she did have Resident L on the week of 5/2/21. The resident had gone to dialysis that morning, so she had not looked at her toe. The resident went to dialysis on Mondays, Wednesdays, and Fridays. She had never seen the resident's toe until she helped assist the evening nurse on Saturday, 5/8/21 to send the resident out to the hospital due to toe pain.

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	05/19/2021

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

(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

LPN 2 had signed off on the TAR she had monitored Resident L's bruised toe on Wednesday, 5/5/21 day and evening shift and Saturday, 5/8/21 day shift.

A physician progress note dated 5/4/21 indicated "...She states that she is not doing well, and she continues to have pain in her right leg in the posterior aspect of her calf. This pain remains localized, sharp, hypersensitive to minimal touch and is consistent throughout the day. She states that she does not believe she has been receiving any pain medication and denies any significant relief for the pain in the right calf...She believes that she has been working well with therapy and has been participating well despite her pain...Did discuss patient's case with the nursing staff and they informed me ....a previous Doppler ultrasound of the right calf was ordered but could not find it per chart review today...Right lower calf pain, hypersensitive. Per chart review and discussion with nursing, there was not yet an order in for a Doppler to rule out blood clot...I personally ordered a Doppler ultrasound of the right calf and communicated directly to nursing verbally and via written script..."

A physician order dated 5/4/21 indicated Resident L was to have a venous Doppler of right lower extremity.

A Venous Doppler ultrasound of right lower extremity dated 5/6/21 indicated Resident L did not have DVT (deep vein thrombosis).

An interview was conducted with Physical Therapist 4 on 5/17/21 at 2:31 p.m. She indicated the resident did have complaints of pain from knee down her lower extremity by just

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	05/19/2021

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

(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
	touching it. Nursing staff was aware. An interview was conducted with Physician 36 on 5/17/21 at 11:03 a.m. He indicated he ordered the venous Doppler on 4/29/21, and it had not been done. He reordered it on 5/4/21 to be done immediately. A change of condition for Resident L dated 5/8/21 indicated "...Skin Status Evaluation: Discoloration Wound... Pain Status Evaluation: Does the resident/patient have pain? Yes...Nursing observations, evaluation, and recommendations are: Palpated pedal weak or absent pulse skin sloughing present possible necrotic tissue swelling to right great toe. Advancing to second toe with hematoma [bruise] on lateral side of the same leg. Cold to touch painful with movement...Primary Care Provider responded with the following feedback: A. Recommendations: Send out urgent due to rapid change in condition...." The hospital records for Resident L dated 5/8/21 indicated admitted with "...Chief complaint. toe pain. RT [right] great toe x 2 weeks, weak pedal pulse great toe dark in color...necrotic great toe with proximal purple discoloration and swelling which extends into two and a small area on 4. Not able to palpate dp [foot pulses]...on r [right] foot. Mild swelling to foot, colder to touch. Full range of motion...Assessment/Plan...Principal Problem: 4. Ischemic ulcer of toe of right foot..Patient states the pain in her toe has been there for a while. Facility reports about 1-2 weeks. Toe is painful, black, with open wound...Has a right common femoral stenosis [narrowing in blood vessel] which is severe and an occluded right popliteal artery [blocked artery lower leg]...She has dry gangrene of her first and			

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	05/19/2021

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

(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
	second toe ...She will likely need a right femoral endarterectomy [removal of blockage] and femoral-tibia bypass [blood redirected through a healthy vessel] She is extremely high risk from an operative standpoint... Podiatry Consult Note...1. Ulceration of the right hallux [toe] with signs of dry gangrene, stable. no clinical infection. 2nd digit early stages of gangrenous changes....Plan: ...patient right foot wrapped with a betadine wet to dry dressing. No sign of infection, no need for antibiotics ...Ulcer can be followed by [name of wound care center] ..." The records indicated Resident L would be placed on palliative care. She was not a candidate for surgical interventions at that time. 2. The clinical record for Resident N was reviewed on 5/12/21 at 3:15 p.m. The diagnoses included, but were not limited to: cellulitis of groin and type 2 diabetes mellitus. A physician order dated 5/7/21 indicated staff was to provide a wound dressing to Resident N's right side of his scrotum every day shift. The order was "...cleanse with normal saline or wound cleanser. Pat dry. Lightly pack with collagen. Cover with dry dressing. every day shift for wound care." A Skin and Wound Evaluation dated 5/11/21 at 7:50 a.m., indicated an assessment was conducted of Resident N's surgical wound to his groin. The measurement of the wound was 0.1 centimeters in area, 0.3 centimeters in length, and 0.5 centimeters in width and 0.3 centimeters in depth. It had light serosanguinous drainage. The old dressing was removed, and the appearance was intact and saturated. An interview was conducted with Resident N on			

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	05/19/2021

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

(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
	Tuesday, 5/11/21 at 3:24 p.m. He indicated the wound team had come in that morning around 7:30 a.m. and removed the dressing on his groin to assess and take pictures. The nurse was supposed to come in to place a new dressing on, but she had not been in yet. The wound dressing on his groin had been off all day. An interview was conducted with License Practical Nurse (LPN) 2 on 5/11/21 at 3:36 p.m. She indicated she was aware the resident did not have a dressing on his wound. She was waiting to place the dressing on after Resident N took his shower. LPN 2 stated she would place the dressing on now. An interview was conducted with Resident N on 5/11/21 at 3:40 p.m. He indicated today was not his shower day. A shower schedule was provided by the Director of Nursing on 5/13/21 at 4:00 p.m. It indicated Resident N's scheduled shower days was on Mondays and Thursdays. 3. The clinical record for Resident T was reviewed on 5/13/21 at 3:47 p.m. Resident T's diagnoses included, but not limited to, diabetes type II, hypertension, congestive heart failure, lymphedema, and anxiety disorder. A Quarterly Minimum Data Set (MDS) dated 4/28/21 indicated, Resident T was cognitively intact and was able to make daily decisions regarding her care. A physician's order placed on 1/21/21 indicated,			

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	05/19/2021

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

(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
	to obtain Resident's weight daily and to report any weight gain of 2 lbs (pounds) in a 24-hour period or a weight gain of >5 lbs in a week. Resident T's recorded weights were as follows: 5/3/21 -- Resident T weighed 444.8 lbs 5/6/21 -- Resident T weighed 463.2 lbs The clinical record did not have weights recorded for the following dates: 5/1, 5/2, 5/4, 5/5, 5/7-5/11, and 5/13/21. The clinical record did not indicate if Resident T's physician was notified of the 18.4 lbs weight gain between 5/3/21 and 5/6/21. The TAR (Treatment Administration Record) was reviewed on 5/13/21. The TAR nor the clinical record provided an explanation as to why Resident T's daily weights were not completed for 5/1, 5/2, 5/5, 5/9, and 5/13 An interview with LPN (Licensed Practical Nurse) 26 was conducted on 5/14/21 at 10:26 a.m. LPN 26 indicated, she had documented Resident T's refusals of being weighed on 5/7, 5/8, 5/10 and 5/13/21. She stated, she thinks she had informed Resident T's physician of the 18.4 lbs weight gain on 5/6/21 yet failed to ensure the clinical record reflected the information. An interview with ADON (Assistant Director of Nursing) was conducted on 5/14/21 at 10:42 a.m. ADON indicated the correct charting for daily weights not recorded would be to indicate why it was not done and not to simply put "no" or "weight not obtained at this time". The notification to physicians regarding weight fluctuation should be in clinical record and in regard to the 5/6/21 weight gain, there is no			

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	05/19/2021

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

(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
	progress note from physician to indicate he was aware of the weight gain on 5/6/21. This resident often refuses weights, and her weight can fluctuate widely. Resident T is noncompliant with diet, eats double portions, and is not concerned about losing weight or maintaining weight. A Following Medication-Physician Orders/Parameters policy was received on 5/14/21 at 11:25 a.m. from the ADON. The policy indicated, "P. Notification of Physician/Prescriber: 1. Persistent refusals. 2. Held medications for pulse, blood pressure, low or high blood sugar, or other abnormal test results, vital signs, resulting in medications being held. 3. Suspected adverse drug reactions. This Federal Tag relates to complaints IN00351254, IN00351434, and IN00353741. 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.			

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	05/19/2021

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

(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
	Based on observation, interview, and record review, the facility failed to follow through with ordering glasses for 1 of 2 residents reviewed for vision and hearing services. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/11/21 at 3:00 p.m. The diagnoses included, but were not limited to, cataracts. The 9/21/20 optometry note included a new glasses prescription. There was no information in the clinical record, including the progress notes, that indicated Resident B's new glasses were ordered or received. The 4/19/21 optometry note included a new glasses prescription with frames. There was no information in the clinical record, including the progress notes, that indicated Resident B's new glasses were ordered or received. An observation of Resident B was made on 5/11/21 at 3:16 p.m. She was watching television in her room, and she was not wearing any glasses. An observation and interview was conducted with Resident B on 5/17/21 at 10:19 a.m. She was holding a pair of red reading glasses in her hand. She indicated they didn't fit her and was unsure if they were hers. An interview was conducted with the SSD (Social	F 0685	1. Resident B was not harmed and glasses were ordered as prescribed. 2. All residents receiving vision and hearing services have the potential to be affected. Most recent vision and hearing visit notes have been reviewed to ensure recommendations are followed. 3. The Dental, Vision, Hearing, Podiatry policy was reviewed and no revisions are necessary. Social services staff will be educated on that policy. The Administrator or his designee will review 10 random recommendations per month for 3 months and until 100% compliance is achieved to ensure recommendations are followed up on, them 10 per quarter for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/18/2021

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	05/19/2021

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

(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
	Services Director) on 5/17/21 at 10:21 a.m. She indicated she spoke with their optometry provider on 5/14/21 who informed her Resident B currently had reading glasses, and new glasses were ordered at that time. A telephone interview was conducted with the Care Coordinator from the facility's optometry provider in the presence of the SSD on 5/17/21 at 10:25 a.m. She indicated Resident B was seen on 9/21/20 and 4/19/21. On 9/21/20, they wrote a new glasses prescription, but the glasses were not ordered, and was unsure as to why. They saw her again on 4/19/21 for a follow up visit, at which time they wrote another prescription for lenses and frames, which were not ordered until 5/14/21 after speaking with the SSD. An interview was conducted with the SSD on 5/17/21 at 10:40 a.m. She indicated usually the provider ordered the glasses for residents after an appointment with a new glasses' prescription. She reviewed the notes afterwards but was not given any separate orders for Resident B, so her glasses did not get ordered until 5/14/21. The Dental, Vision, Hearing, Podiatry Services policy was provided by the SSD on 5/17/21 at 1:59 p.m. It read, "The Social Service Director or designee will follow up on all referrals until completed." 3.1-39(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.			

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	05/19/2021

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

(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
	Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a resident's wheelchair cushion was functioning properly, as ordered, for 1 of 2 residents reviewed for pressure ulcers. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/11/21 at 3:00 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis. The 5/5/21 Braden Scale for Predicting Pressure Sore Risk assessment indicated she was at moderate risk for developing pressure ulcers and was, "Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair." The pressure ulcer care plan, revised 1/20/20, indicated she was at risk for developing pressure ulcers related to decreased mobility, requiring increased assistance with bed mobility and transfers.	F 0686	1. Resident B was not harmed and her cushion was turned on immediately upon notification. 2. All residents with mechanical pressure-relieving devices have the potential to be affected and those with specific cushions and mattresses were checked immediately to ensure functioning as ordered. 3. The Care Planning policy was reviewed and no revisions are indicated. Staff will be educated on this policy. The DON or her designee will round on 5 random residents with care-planned mechanical devices twice weekly for 4 weeks and until 100% compliance is achieved to ensure devices are functioning properly, then weekly for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/18/2021

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	05/19/2021

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

(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
	The physician's orders indicated she had scar tissue on her sacrum with skin prep and a foam dressing to be applied every 3 days as a preventative measure. The orders read, "Low air loss wheelchair cushion in place and functioning properly with settings between 90 and 110, every shift for prevention," effective 3/26/21. An observation of Resident B was made on 5/18/21 at 11:20 a.m. She was sitting in her wheelchair in her room. Her wheelchair cushion was in place, but not functioning, as it was not currently running. An observation of Resident B was made on 5/18/21 at 11:21 a.m. with LPN (Licensed Practical Nurse) 10. An interview was conducted with LPN 10 during this observation. LPN 10 bent over and looked at the box, located on the back of Resident B's wheelchair, that controlled the low air loss cushion. LPN 10 indicated the machine was not on and proceeded to turn it on by pressing a button on the box. Afterwards, the machine lit up and began making a low humming noise. An observation and interview was conducted with Resident B on 5/19/21 at 10:43 a.m. She was sitting in her wheelchair in her room. Her wheelchair cushion was in place, but not functioning, as it was not currently running. Resident B indicated she was not comfortable in her wheelchair. An observation of Resident B was made on 5/19/21 at 10:44 a.m. with QMA (Qualified Medication Aide) 14. An interview was conducted with QMA 14 during this observation. QMA 14 bent over and looked at the box on the back of Resident B's wheelchair. QMA 14			

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	05/19/2021

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

(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
	indicated the aides who assisted Resident B with transferring into her wheelchair should have turned on her cushion at that time. QMA 14 proceeded to turn on the machine. Afterwards, the machine lit up and began making a low humming noise. The Care Planning policy was provided by the Nurse Consultant on 5/19/21 at 2:29 p.m. It read, "The services provided or arranged by the facility, as outlined in the comprehensive plan of care must: ...Be provided by a qualified person in accordance with the written plan of care." 3.1-40(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and			

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	05/19/2021

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

(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
	nasal-pharyngeal ulcers. Based on observation, interview, and record review the facility failed check for placement and residual prior to administering medications and provide a water flush after administering medications via a gastrostomy tube for 1 of 2 residents reviewed for gastrostomy tubes (Resident R) Findings include: The clinical record for Resident R was reviewed on 5/17/21 at 5:09 p.m. The Resident's diagnosis included, but were not limited to, cerebral palsy and aphasia. A Quarterly MDS (Minimum Data Set) Assessment, completed 4/29/21, indicated he received his nutrition and hydration via a gastrostomy tube. A physician's order, dated 11/21/2019, indicated to check tube feeding residual before medications and feedings. If greater than 100 ml (milliliter) to hold the feeding and/ or medication and notify the physician. A care plan, revised on 10/10/2019, indicated that he had a gastrostomy tube related to his NPO (Nothing by Mouth) status, with an intervention to check for placement of the tube prior to administering medications. On 5/13/21 at 5:09 p.m., LPN (Licensed Practical Nurse) 28 was observed administering medications to Resident R. He poured 10 ml of Keppra (seizure medication) into a medication cup. He then poured the Keppra into a glass of water. He entered the room and set up his	F 0693	1. Resident R's tube placement was checked upon notification and the tube remained patent and flushed with ease. 2. All residents with enteral tubes have the potential to be affected. Tubes were checked for placement and patency without concern. 3. The policy on Checking Placement of Feeding Tubes was reviewed and no revisions are indicated. Licensed staff will be educated and competency checks completed on this policy/procedure. The DON or her designee will observe 5 random nurses weekly for 4 weeks and until 100% compliance is achieved to ensure proper technique is executed, then 5 random nurses per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/18/2021

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	05/19/2021

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

(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
	supplies on the bedside table, put on a pair of disposable gloves, turned off the continuous feeding pump and disconnected the gastrostomy tube from the feeding. He inserted a piston syringe into the gastrostomy tube and poured the mixture of water and medication into the piston syringe. He then inserted the plunger into the piston syringe and slowly pushed the water and medication mixture into the gastrostomy tube, disconnected the piston syringe from the gastrostomy tube and replaced the continuous feeding tube into the gastrostomy tube and restarted the feeding pump. He did not flush the gastrostomy tube with water prior to reattaching the feeding. During an interview on 5/13/21 at 5:20 p.m., LPN 28 indicated this was how he normally gave Resident R's medication. He checked for placement and residual at the beginning of the shift and did not check again prior to giving his medications. On 5/14/21 at 8:49 a.m., the DON (Director of Nursing) provided the Checking Placement of Feeding Tubes Policy, revised January 2019, which read "...Policy: It is the policy of the facility to check the placement of feeding tubes before medications, feedings and flushes...2. To check for residual in gastrostomy tubes to determine placement...a. using a 60 ml catheter tip syringe, aspirate the tube for gastric contents. b. If the residual exceeds 100 ml, hold the feeding, and notify practitioner. c. If there is no excessive residual feeding, return the gastric contents to the stomach..." 3.1-44(a)(2)			

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	05/19/2021

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

(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 0697 SS=E Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to perform nonverbal pain assessments for a resident with aphasia and cognitive impairment, provide pain medication timely for a newly admitted resident, and ensure a resident's pain was addressed timely for 4 of 5 residents reviewed for pain. This resulted in continued pain and delayed treatment of pain for a resident and a resident being transferred to hospital with complaints of toe pain. (Resident L, D, G and F) Findings include: 1. The clinical record for Resident L was reviewed on 5/18/21 at 11:30 a.m. The diagnoses included, but were not limited to: heart failure, stroke, cardiac arrest, acute respiratory failure and chronic kidney disease. Resident L was admitted to the facility on 4/24/21 and discharged to hospital on 5/8/21. An Admission Minimum Data Set (MDS) dated 5/1/21, indicated Resident L was moderately cognitively impaired. A skin care plan dated 5/3/21 indicated "I have skin failure (bruise) related to recent fall to my R foot, 1st digit [toe]...Goal I will state my pain	F 0697	1. Residents D, G and F's pain evaluations were reviewed for accuracy and reassessed as indicated, care plans reviewed and revised, and checked to ensure medication is available. Resident L no longer resides at the facility. 2. All residents have the potential to be affected. Pain evaluations and care plans will be reviewed for accuracy and revised as indicated. An audit will be completed to ensure medication availability. The IDT will review all new or worsening behaviors to determine if pain could be root cause. 3. The Pain Evaluation, Care Planning and EDK Use policies have been reviewed and no revisions are necessary. Staff will be educated on these policies. The IDT will be educated on the Behavior Management Program along with staff. The DON or her designee will review 10 residents per week to ensure pain evaluations are accurate, care plans are in place and medications are available for 4	06/18/2021

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	05/19/2021

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

(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
	is managed with my care plan interventions..." The clinical record did not include a care plan with interventions in place to address her pain. A Physical Therapy Evaluation dated 4/26/21 indicated on pain assessment "...patient states she is having pain that has been going on for a while. Patient did demonstrate pain behaviors when palpating R [right] calf...Patient winces/grimes with any movement of RLE [right lower extremity]...behaviors exhibited: moaning, grunting, facial grimacing and tense with any passive movement to RLE..." A physician progress note dated 4/27/21 indicated Resident L "...seated in her wheelchair comfortably. She appears mildly lethargic on exam but is alert and answers questions appropriately when prompted. She states that she is doing well, she is not currently having any pain...6. Pain. Patient not endorsing any pain currently and does not have any medications for pain per chart review. We will monitor..." A physician progress note for Resident L dated 4/29/21 indicated "...Today, she is endorsing right leg pain, it is in the posterior calf, localized, sharp, hypersensitive to minimal touch, it is fairly constant throughout the day. She denies any significant relief for it. She has no pain medication at this point. She denies any other relief....Her pain does get worse with walking....pain...tramadol 50 mg [milligrams] 2x [twice] a day..." A physician order dated 4/29/21 indicated Resident L was to receive 50 milligrams of tramadol twice a day for pain.		weeks and until 100% compliance is achieved then 10 per month for 6 months and until 100% compliance is maintained. The SSD will review 3 residents with new or worsening behaviors weekly, or all if less than 3, to ensure root cause analysis is conducted and documented and pain is being/has been ruled out. This will continue for 4 weeks and until 100% compliance is achieved then 5 per month for 6 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	05/19/2021

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

(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
	A Physical Therapy note dated 4/30/21 indicated "...Pain - At Rest = 0/10...Pain with movement = 8/10; Frequency = Intermittent..." An interview was conducted with Physical Therapist 4 on 5/17/21 at 2:31 p.m. She indicated the resident did have complaints of pain from knee down her lower extremity by touch. The resident's pain was worse with movement. The nursing staff was aware she needed pain medication. It was affecting her participation in therapy. A nursing progress note dated 5/1/21 indicated Resident L's tramadol was still on order from pharmacy. A nursing progress note dated 5/2/21 indicated "on call physician called back. Informed nurse that tramadol will not be called in due to resident coming into facility with cardiac arrest. Said she would leave a note for physician to come review med [medications] in am [a.m.]..." A physician note dated 5/3/21 indicated Resident L was being seen for pain in her right big toe. "...Musculoskeletal: Extremities no lower leg edema. Right big toe cold, erythema [redness], tender to touch, weak pulse...6. Great toe pain, right. Suspect ischemia [reduction in blood flow] will have vascular see her today per her follow up..." A nursing progress note dated 5/3/21 indicated tramadol was unavailable. A nursing progress note dated 5/4/21 indicated "...Script needed on call notified awaiting return call..."			

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	05/19/2021

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

(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
	A physician progress note dated 5/4/21 indicated "...She states that she is not doing well and she continues to have pain in her right leg in the posterior aspect of her calf. This pain remains localized, sharp, hypersensitive to minimal touch and is consistent throughout the day. She states that she does not believe she has been receiving any pain medication and denies any significant relief for the pain in the right calf...She believes that she has been working well with therapy and has been participating well despite her pain...Did discuss patient's case with the nursing staff and they informed me that they are still awaiting for an E-script [electronic prescription] for pain medication..." An interview was conducted with Physician 35 on 5/17/21 at 11:18 a.m. He indicated there was a delay with starting Resident L's pain medication. He had written a prescription for the tramadol unaware the pharmacy was needing an E-script [electronic prescription] due to the pain medication was classified as a narcotic. A Narcotic Count Sheet for Resident L indicated the resident had received tramadol twice a day on 5/5/21, 5/6/21, and 5/7/21. She had received the tramadol once on 5/8/21 then hospitalized. A change of condition for Resident L dated 5/8/21 indicated "...Skin Status Evaluation: Discoloration Wound...Pain Status Evaluation: Does the resident/patient have pain? Yes...Nursing observations, evaluation, and recommendations are: Palpated pedal weak or absent pulse skin sloughing present possible necrotic tissue swelling to right great toe. Advancing to second toe with hematoma [bruise] on lateral side of the same leg. Cold to touch painful with movement...Primary Care Provider			

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	05/19/2021

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

(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
	responded with the following feedback: A. Recommendations: Send out urgent due to rapid change in condition..." The hospital records for Resident L dated 5/8/21 indicated admitted with "...Chief complaint. toe pain. RT [right] great toe x 2 weeks, weak pedal pulse great toe dark in color...necrotic great toe with proximal purple discoloration and swelling which extends into two and a small area on 4. Not able to palpate dp [foot pulses]...on r [right] foot. Mild swelling to foot, colder to touch. Full range of motion...Assessment/Plan...Principal Problem: 4. Ischemic ulcer of toe of right foot...Patient states the pain in her toe has been there for awhile. Facility reports about 1-2 weeks. Toe is painful, black, with open wound...Has a right common femoral stenosis [narrowing in blood vessel] which is severe and an occluded right popliteal artery [blocked artery lower leg]...She has dry gangrene of her first and second toe. ...She will likely need a right femoral endarterectomy [removal of blockage] and femoral-tibia bypass [blood redirected through a healthy vessel] She is extremely high risk from an operative standpoint... Podiatry Consult Note...1. Ulceration of the right hallux [toe] with signs of dry gangrene, stable. no clinical infection. 2nd digit early stages of gangrenous changes...Plan: ...patient right foot wrapped with a betadine wet to dry dressing. No sign of infection, no need for antibiotics ...Ulcer can be followed by [name of wound care center] ..." The records indicated Resident L was treated in the emergency room with morphine on 5/8/21 for pain. During her hospitalization, it was decided she would be placed on palliative care. She was not a candidate for surgical interventions at that time. At the time of discharge, Resident L was to continue taking 50 milligrams of tramadol twice			

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	05/19/2021

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

(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
	daily. 2. The clinical record for Resident D was reviewed on 5/12/21 at 10:00 a.m. The diagnoses included, but were not limited to: mixed receptive-expressive language disorder, aphasia, hemiplegia, and hemiparesis. She was admitted to the facility on 11/1/20. The 4/30/21 Quarterly MDS (Minimum Data Set) assessment indicated Resident H had pain in the past 5 days, occasionally, with a pain intensity of 5 on a 1 through 10 pain level scale. On 5/14/21 at 3:20 p.m., an interview was conducted with the MDS Coordinator, who conducted the pain assessment for the 4/30/21 Quarterly MDS assessment. She indicated she did not ask the location of Resident D's pain, but she remembered her holding up 5 fingers to indicate her pain level. There was no pain care plan in Resident D's clinical record. The most recent documented pain assessment was dated 3/6/21. It indicated her most recent pain level was 0 on 3/5/21, and that she sometimes complained of abdominal discomfort. The physician's orders included gabapentin 300 mg twice daily for pain from 12/7/20 through 5/12/21. It did not include any other regularly scheduled medications for pain. There was an as needed order for Tylenol for fever and an as needed order for Voltaren gel for joint pain. Per the May 2021 MAR (medication administration record,) neither PRN medication was administered.			

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	05/19/2021

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

(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
	An interview and observation was conducted with Resident D on 5/12/21 at 10:10 a.m. She had scratches on her left arm, near her wrist. Communication with Resident D was difficult, due to her diagnoses, but she nodded yes to the affirmative when asked if she was hurting. She became teary eyed and grimaced. During this observation, LPN (Licensed Practical Nurse) 10 entered the room and began communicating with Resident D. Resident D was making a waving motion up and down her right arm. Eventually, LPN 10 called Resident D's son and daughter and communicated to them the motions Resident D was communicating to her. An interview was conducted with LPN 10 on 5/14/21 at 11:24 a.m. She stated, "Remember when she kept doing the waves with her hand up and down her right side and made certain noises?" LPN 10 indicated after speaking with Resident D's son and daughter on 5/12/21, they informed her Resident D was indicating pain. She confirmed with Resident D that she was in pain, so she had the physician evaluate her and x-rays were ordered. When the results came back with a fracture, they sent her out for a cast. The 5/12/21 radiology report read, "Forearm AP and Lat, right Comparison: 11/17/20...Results: There is an age-indeterminate fracture of the distal right radius. There is mild displacement of the distal fragment. There are no gross lytic or blastic lesions in the bones. There is no dislocation. Bone demineralization is present. Degenerative joint disease is present in the radiocarpal and intercarpal joints. Conclusion: There is an age-indeterminate fracture as described above. Correlate with timing of trauma and tenderness. Bone demineralization is present. Degenerative joint disease is present in			

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	05/19/2021

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

(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
	the radiocarpal and intercarpal joints. The exam is overall worse compared with prior." The 5/13/21 orthopedic note read, "The patient presents for evaluation of a right hand/wrist problem. This problem occurred 2021-05-10. There was not a specific injury that caused this problem. The onset of pain was sudden. The patient is experiencing pain, stiffness, swelling, and weakness. The patient has no radiating sensation. The patient describes their pain as aching, sharp and throbbing. The patient's pain is constant and getting worse. The patient's present pain level is 9/10. The patient's pain is exacerbated by nothing. The patient's pain is relieved by nothing....Patient presents today with a caregiver for right arm pain. She states it is primarily in the wrist. Patient has had a stroke and she has weakness on the right side. She does not speak much but has been complaining about arm pain for several months now. They did x-rays at the facility of the entire arm. They have noticed though that the swelling is primarily around the wrist which is her side of complaint. Patient has limited movement of that arm. It is swollen. She clenched her fists as well...Results/Data...Views: AP and lateral views were performed and an oblique view was performed of the right wrist. Findings: Her x-ray was read today, no fracture, normal alignment, no bony lesions, the soft tissues were normal and joint spaces were normal...Assessment 1. Right wrist pain...Plan: 1. Patient was placed into a cock-up wrist brace. I also placed her in a sling. She was much more comfortable with both on. She will wear the sling when she is up during the day but take it off at night. The brace will be worn most the time. She may take it off to bathe. 2. We will see her back in 1-2 weeks to evaluate her progress....I did recommend icing it and she			

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	05/19/2021

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

(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
	will let them know to ice a couple times a day." The 5/13/21, 12:52 p.m. nurses note read, "Late Entry: Narrative: Res [Resident] return from [name of orthopedic clinic] immediate Care with a spling [sic] and sling to rt. [right] arm. Res has a return appt on Tuesday 5/18/2021 at 9:15am with [name, address, and phone number of physician.]" An interview was conducted with LPN 10 on 5/14/21 at 2:30 p.m. She indicated she'd worked at the facility for the past 2 weeks on the day shift and assessed Resident D for pain daily. She assessed her for pain by asking if she had pain or if she was okay but did not document the assessments anywhere. 5/12/21 was the first time she'd ever seen her rub up and down her arm like that, and that was the first time she'd assessed her as having pain. None of the staff had ever informed her of nonverbal signs of pain or her holding her right arm, and she'd never seen her do those things before. An interview was conducted with CNA (Certified Nursing Assistant) 18 on 5/14/21 at 2:23 p.m. She indicated she'd worked at the facility for 2 years and Resident D often grimaced during care and held her right arm. Resident D did not want staff to touch it. She worked with Resident D on day shift, 5/10/21, and Resident D "was already holding her arm when I got in there." CNA 18 indicated she informed the nurse but didn't remember who the nurse was. She stated, "I always tell the nurse she's in pain. They will come in and do a pain assessment, hold up their fingers to have her say yes to level of pain." An interview was conducted with CNA 19 on 5/14/21 at 2:47 p.m. She indicated she'd worked at the facility for nearly 2 years and stated, "I			

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	05/19/2021

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

(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
	have noticed a couple of weeks ago, ever since she's been in that room, that when we go to put her in the lift or turn her in bed, she'll grab and hold that right arm, like she'd rather move it than us. I just noticed it a couple of weeks ago. I told the nurse, not sure who. They went in the room and talked to her, not sure what she did in there. I didn't stay." 3. The clinical record for Resident G was reviewed on 5/11/21 at 1:16 p.m. The Resident's diagnosis included, but were not limited to, speech and language deficit following a cerebral infarct and dementia. He was admitted to the facility on 2/12/2021. A Quarterly MDS (Minimum Data Set) Assessment, completed 4/23/21, indicated that he was severely cognitively impaired and that he had an open lesion on his foot. A care plan, revised on 5/5/21, indicated he had behavioral symptoms, such as yelling out, combativeness, cursing, calling staff names, and hitting staff due to his diagnosis of dementia and delirium. The goal of the care plan was for his behavioral symptoms to be managed through care plan intervention. The interventions included, but were not limited to, approach him from the front, administer his medications as ordered and to provide comfort and reassurance when he was upset to assist him to calm down. A care plan, revised on 4/24/21, indicated he had difficulty understanding others and making himself understood related to aphasia with a goal that he will be able to effectively communicate his wishes and understand others. The intervention included, but not limited to, reduce stimulation and background noise as necessary			

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	05/19/2021

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

(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
	and allow me time to process information. A Speech Therapy Evaluation and Plan of Treatment, dated 4/14/21, indicated that he was referred to speech therapy due to recent behaviors. He had had previous speech therapy while in an acute care hospital which revealed severe expressive and receptive language skills. He currently had impaired receptive and expressive language skills and cognitive-communication skills. The clinical impression was that he was able to talk about motorcycles for 10 minutes but was unable to name an animal when asked what the name was. He required skilled speech therapy for cognition / communication to enhance cognitive skills and decreased adverse behaviors. There was no pain care plan present in the clinical record until 5/14/21. On 4/3/21 at 10:28 p.m., a Behavior Sheet was completed, which indicated he displayed resistance to care. He would not allow his treatment to be performed on his left great toe and said it was sensitive to touch. He began kicking and using profanity. He was reapproached and continued to refuse. On 5/13/21 at 10:21 a.m., Resident G was observed in a common area attending an activity. He was sitting calmly in his wheelchair with his feet sitting on the floor under his foot pedals. His feet were swollen, and he was wearing socks and no shoes. At the end of the activity program a staff member approached him and asked him if he would like to go to the next activity. She bent down to attempt to put his feet on the foot pedals, and he told her not to touch his feet. She continued to try to move his feet to the foot			

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	05/19/2021

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

(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
	pedals and he then loudly told her not to touch his feet and began reaching out for her hands as if to push them aware from his feet. Another staff member came over to assist with moving him to the next activity. He continued to tell them not to touch his feet and began to use his clenched fist to swing at the staff members. The staff members offered to lay him in bed to rest. He agreed and they had him pick his feet up, moved the wheelchair pedals to the upright position and wheeled him to his room. The staff member took him to his room and shut the door. He could be heard inside of the room talking loudly, and then the door to the room opened and the staff member wheeled him back into the hallway. She indicated that he decided not to lay down. He was moved to the common area and provided a soft drink. He then thanked them and drank the soft drink. On 5/13/21 at 4:42 p.m., the DON (Director of Nursing) provided a Podiatry Progress Note, dated 3/31/21. The problem list included pain in the right and left toe and diabetic peripheral neuropathy. He was seen for a complain of pain in both feet and long nails. He reported that the quality of the pain was achy. His family member had accompanied him to the appointment and informed the Podiatrist that he had a vascular work up earlier in 2021. There was gangrene present in the foot. A Podiatry Progress Note, dated 4/27/21, indicated he was seen for pain in both of his feet. The quality of the pain was sharp and cramping and that rest helped make it feel better. He was accompanied by his family member to the appointment. He had edema (swelling) in both of his feet. There was gangrene present in the foot.			

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	05/19/2021

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

(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
	During an interview on 05/14/21 at 10:52 a.m., FM (Family Member) 33 indicated that she had taken him to the podiatrist on 3/31/21. His toenails had been in bad shape and the Podiatrist had cut them. She had taken him back to the Podiatrist on 4/27/21 and she had recommended a doppler (circulation test) be done due to the open area on his toe. The Podiatrist had discussed the gangrene present in his foot with her. She had taken him to the vascular surgeon for the doppler exam, but they could not do the entire exam because it had caused him pain. He frequently complained of pain in his feet and if they were barely touched, he would go "crazy". She had told the facility about his painful feet. She did not want to pursue further treatment for the gangrene due to his overall declining health and that the vascular surgeon had discussed that he was not a good candidate for surgery due to his underlying health conditions. She just wanted him to be comfortable. During an interview on 5/14/21 at 1:36 p.m., the WN (Wound Nurse) indicated she had been measuring the open area on his right toe weekly since 4/7/21. She had not reviewed the podiatry progress note from 3/31/21 but had spoken with Family Member 33 about his treatment. She had questioned him about pain, and he had denied having pain. She had not done a non-verbal pain assessment because he was able to speak. She performed non-verbal pain assessments when someone had aphasia or was unable to verbalized pain. She was unaware of the gangrene until he came back from the hospital on 5/10/21. During an interview on 05/14/21 at 2:42 p.m., ST (Speech Therapist) 24 indicated his ability to understand what said to him and to express what he wanted was decreased. He would frequently			

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	05/19/2021

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

(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

tell her not to touch his toe, but she would be nowhere near his feet. He would ask to go the bathroom and then deny needing to use the bathroom when he got there. She believed that the expressive and receptive disorder, along with his dementia, made it difficult for him to understanding what was said to him and expressing needs he may have. His family member had expressed this was happening when she cared for him at home, but it had become worse after the stroke.

On 5/14/21 at 3:09 p.m., CNA (Certified Nursing Assistant) 32 and QMA (Qualified Medication Aide) 31 were interviewed. CNA 32 indicated that when she would assist with doing the treatment to his feet, he acted like it was tender and hurt. He also hurt when she assists him with transfers. QMA 31 had been informed that he was started on routine pain medication on 5/14/21.

A physician's order, dated 5/14/21, indicated he was to receive Tylenol 500 mg (milligram) 3 times a day routinely.

A care plan, initiated on 5/14/21, indicated he had a potential for acute pain related to his wounds, with a goal that he would exhibit nonverbal signs of pain, such as restlessness, facial grimacing, guarding of affected area, or yelling out, no more than 1 time each shift. The interventions included, but were not limited to, administering pain medication as ordered, observing for nonverbal signs and symptoms of pain prior to care and having staff observe to determine if he was having non-verbal signs of pain.

4. The clinical record for Resident F was

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	05/19/2021

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

(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
	reviewed on 5/14/21 at 3:30 p.m. The Resident's diagnosis included, but were not limited to, skin abscess of the perineum and congestive heart failure. He was admitted to the facility on 3/23/21. An Admission MDS (Minimum Data Set) Assessment, completed 3/30/21, indicated he was cognitively intact and had experienced pain frequently. The pain had caused him to lose sleep at night and he rated the pain as a 10, on a scale of 1-10. A physician's order, dated 3/23/21, indicated he could receive 1 tablet of hydrocodone-acetaminophen (narcotic pain medication) 5-352 mg (milligram) every 6 hours as needed for pain. A physician's order, dated 3/23/21, indicated he could receive 600 mg of ibuprofen every 6 hours as needed for mild pain. The clinical record did not contain a care plan addressing pain. A progress note, dated 3/23/21 at 9:45 p.m., indicated that his new admission orders had been reviewed and that a script (prescription) for Norco (narcotic pain medication) had been sent to the pharmacy. During an interview on 5/17/21 at 8:43 a.m., Resident F indicated that he had not received his narcotic pain medication the first night that he was at the facility. He had requested the pain medication and the nurse had told him that it wasn't available yet. The nurse had offered him Advil (ibuprofen) instead of the narcotic. He had not wanted to take the Advil, because he had heart			

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	05/19/2021

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

(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
	issues and was on a blood thinner. His heart doctors had told him, in the past, not to take it. He had asked the nurse again later about the narcotic pain medications and was told again that they weren't available. He was in a lot of pain, so he took the ibuprofen. He had not received his narcotic pain medications until early the next morning. A progress note, dated 3/24/21 at 6:09 a.m., indicated that the pharmacy had approved a dose of hydrocodone-acetaminophen 5-325 mg been taken from the EDK (Emergency Drug Kit). The April 2021 MAR (Medication Administration Record) indicated he had received his 1st dose of hydrocodone on 3/24/21 at 6:09 a.m. His pain level had been assessed at a 7 out of 10. During an interview on 5/19/21 at 9:30 a.m., the Nurse Consultant indicated that no hydrocodone-acetaminophen 5-325 mg had been taken from the EDK for Resident F prior to 3/24/21 at 6:09 a.m. On 5/14/21 at 12:10 p.m., the Assistant Director of Nursing provided the Pain Evaluation Policy, revised March 2020, which read "... Purpose: To establish guidelines to measure a resident's level of pain. To provide optimal comfort through a pain control plan, which is established with the members of the health care team.... 1. Residents will have a pain evaluation completed upon admission, quarterly, and when the resident experiences new pain in a different location. 2. When completing the pain evaluation, the nurse will assess the resident pain level at the time the evaluation is being completed and will include any current diagnosis that may indicate pain and			

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	05/19/2021

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

(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
	any pain that occurred over the past week in the quarterly evaluation. On admission the nurse will assess only the current level of pain and any diagnosis that may indicate a risk for pain. 3. Residents will have pain assessed routinely with each dose of pain medications given; therefore a new pain evaluation will not be required after changes in medications... 4. A resident with cognitive impairment who is unable to verbalized pain will have a PAINAD completed. 5. The resident will be asked to use the pain scale to rate their level of pain both on the evaluation and with the administration of pain medications. Numeric pain scale- '0 to 10'. '0' being no pain and '10' being the worst pain he / she has had... 6. Nursing will document any complains or signs/symptoms of pain the progress note as indicated. 7. The pain scale will be used to determine the effectiveness of pain interventions. 8. Family / Resident Representative should be involved in providing information on any remedies that may have provided relief previously. 9. The resident will have a care plan developed for their pain control with established interventions, and this will be reviewed on a quarterly basis and as needed with change." On 5/19/21 at 10:15 a.m., the Nurse Consultant provided the Narcotic Emergency Drug Kit Usage Policy, approved 2/1/2018, which read "Policy: To ensure that Narcotic Emergency Drug Kits [EDK] are utilized in a manner compliant with State and Federal regulations...3. Physicians Order and the Narc EDK a. Every medication removed from the Narc EDK must be accounted for b. Every medication removed from the Narc EDK must have an accompanying physician's order and valid prescription or verbal authorization. The physician's order and valid			

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	05/19/2021

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

(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
	prescription or verbal authorization must be on file with the pharmacy..." 3.1-37(a) This Federal tag relates to complaint IN00351254, IN00351434, and IN00353741.			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review, the facility failed to ensure residents that go to dialysis were provided a snack or supplement to take with them for 2 of 2 residents reviewed for dialysis. (Resident K and M) Findings include: 1. The clinical record for Resident K was reviewed on 5/12/21 at 10:00 a.m. The diagnoses included, but were not limited to: end stage renal disease, type 2 diabetes mellitus and acute respiratory failure. A Quarterly Minimum Data Set (MDS) dated 4/15/21, indicated Resident K was cognitively intact. A dialysis care plan for Resident K dated 2/28/21 indicated "I have end stage renal disease requiring dialysis....Interventions...I will receive a snack or supplement to take with me to dialysis	F 0698	1. Residents K and M were not harmed. Residents were offered snack upon return from dialysis. 2. All residents receiving dialysis services have the potential to be affected. See below for corrective measures. 3. Staff were educated on the Dialysis policy. The DON or her designee will check to ensure snacks/meals/supplements were sent with all residents going out for dialysis 3 times weekly for 4 weeks and until 100% compliance is achieved, then weekly for 4 weeks and until 100% compliance is maintained, then monthly for 6 months to ensure compliance is maintained. 4. The findings of these audits will be reviewed during the facility's monthly QAPI meetings and the plan of action adjusted	06/18/2021

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	05/19/2021

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

(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
	center..." A physician order dated 4/8/21 indicated Resident K received dialysis on Tuesdays, Thursdays and Fridays. A physician order 4/16/21 indicated Resident K was to receive a once-a-day Nepro supplement Tuesdays, Thursdays, and Saturdays to take with her to dialysis. The May 2021 Medication Administration Record indicated Resident K had received a Nepro supplement to take with her to dialysis on the following days: 5/1/21, 5/4/21, 5/6/21, 5/8/21, 5/11/21, 5/13/21, 5/15/21, and 5/18/21 An interview was conducted with Resident K on 5/12/21 at 10:21 a.m. She indicated she was not offered a snack or supplement to take with her to dialysis. She eats breakfast prior to leaving for dialysis, and then provided dinner when she returns. An observation was made of Resident K on 5/13/21 at 11:22 a.m. She was observed getting transported to a stretcher and leaving for dialysis. The transport staff prior to leaving went to nurse's station and was handed paperwork by nursing staff. The transport service, and the resident left the building. Resident K was not observed with Nepro supplement or a snack. The nursing staff was not observed offering the resident a snack or supplement to take with her. 2. The clinical record for Resident M was reviewed on 5/12/21 at 10:21 a.m. The diagnoses included, but were not limited to: end stage renal disease and type 2 diabetes mellitus.		accordingly.	

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	05/19/2021

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

(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
	A Quarterly Minimum Data Set (MDS) dated 5/4/21, indicated Resident M was cognitively intact. A care plan for Resident M dated 3/2/21 indicated "I have end stage kidney disease requiring dialysis...Interventions: I will participate in my dialysis as scheduled on Tuesday, Thursday and Saturday..." A care plan dated 2/23/21 indicated "I have end stage renal disease requiring dialysis. I have history of missing my dialysis runs. My weight fluctuates. I have had gains and losses...Interventions...I will take a packed lunch to take with me to dialysis center..." An interview was conducted with Resident M on 5/12/21 at 9:50 a.m. He indicated he was not provided sacked lunches to take with him to dialysis. An observation was made of Resident M leaving for dialysis on 5/14/21 at 3:02 p.m. The resident was observed transferred to stretcher by transport services. The transport staff walked to nurse's station and picked up paperwork. Then the resident and transport service was observed leaving the facility. Resident M did not have a sack lunch with him. The nursing staff was not observed offering a sack lunch to the resident. An interview was conducted with License Practical Nurse (LPN) 2 and LPN 3 on 5/18/21 10:30 a.m. LPN 3 indicated she was Resident M's nurse that day. Resident M had already left for dialysis. The dialysis residents are provided a sack lunch to take with them to dialysis. They are stored in the dining room's refrigerator by the dietary staff. At that time, there was an			

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	05/19/2021

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

(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
	observation of the refrigerator with LPN 3. There were two paper bags dated 5/18/21, in the refrigerator with Resident M's name on it and Resident K. LPN 3 indicated it was the transporting staff's responsibility to get the sacks from the refrigerator prior to taking the residents to dialysis. Resident M did not have his sack lunch for the day. LPN 2 indicated she was Resident L's nurse. Resident L always refuses her sack lunch and supplement on dialysis days. She does not feel good on those days and declines to take them. LPN 2 indicated staff should be documenting the refusals in the system and her care plan should be updated. An interview was conducted with Dietary Aide 10 on 5/18/21 at 11:31 a.m. The dietary staff does have to frequently remove sacked lunches from the refrigerator that were prepared for residents to take with them to dialysis that were not sent with them. 3.1-37(a)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review the facility failed to timely update and implement an interdisciplinary plan of care for a resident with dementia who displayed behaviors and a dementia resident with a history of wandering and leaving the building unattended for 2 of 3 residents reviewed for dementia care (Resident G and O)	F 0744	1. Residents G and O have been reviewed, plans of care revised and the Behavior Management program initiated. 2. All residents exhibiting behaviors have the potential to be affected. All behavior care plans reviewed and revised as needed	06/18/2021

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	05/19/2021

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

(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
	Findings include: 1. The clinical record for Resident G was reviewed on 5/11/21 at 1:16 p.m. The Resident's diagnosis included, but were not limited to, speech and language deficit following a cerebral infarct and dementia. He was admitted to the facility on 2/12/2021. A Quarterly MDS (Minimum Data Set) Assessment, completed 4/23/21, indicated that he was severely cognitively impaired. On 4/3/21 at 9:31 a.m., a Behavior Sheet was completed, which indicated he had yelled, screamed, and cursed at the staff. He had told the staff to shut up. When staff tried to talk with him to change his behavior it had remained unchanged. He was left alone and calmed himself down. On 4/3/21 at 10:28 p.m., a Behavior Sheet was completed, which indicated he displayed resistance to care. He would not allow his treatment to be performed on his left great toe and said it was sensitive to touch. He began kicking and using profanity. The task was broken into small steps and his behavior was unchanged. He was reapproached and continued to refuse. A Psychiatry progress noted, dated 4/7/21, indicated he had been experiencing significant issues since he was last seen on 3/4/21. He was started on Haldol (antipsychotic) 2.5 mg 3 time a day due to possible delirium. The clinical record did not contain an IDT (Interdisciplinary Team) note or a behavior meeting note indicating the behaviors had been		and Behavior Management program initiated. 3. The Behavior Management program has been reviewed and no revisions necessary. Staff, including IDT members, will be educated on the Behavior Management program. The SSD will review 3 residents with new or worsening behaviors weekly, or all if less than 3, to ensure root cause analysis is conducted and documented and pain is being/has been ruled out. This will continue for 4 weeks and until 100% compliance is achieved then 5 per month for 6 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	05/19/2021

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

(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

reviewed or that new non-pharmacological interventions had been reviewed. There was no care plan for behaviors was present in the clinical record at that time.

A Speech Therapy Evaluation and Plan of Treatment, dated 4/14/21, indicated that he was referred to speech therapy due to recent behaviors. He had previous speech therapy while in an acute care hospital which revealed severe expressive and receptive language skills. He currently had impaired receptive and expressive language skills and cognitive-communication skills. The clinical impression was that he was able to talk about motorcycles for 10 minutes but was unable to name an animal when asked what the name was. He required skilled speech therapy for cognition / communication to enhance cognitive skills and decreased adverse behaviors.

On 4/16/21 at 12:36 a.m., a Behavior Sheet indicated he had displayed the behavior of picking the skin off his feet. He was removed from the situation and the behavior improved.

On 4/23/21 at 6:38 a.m., a Behavior Sheet indicated he was yelling and screaming at staff, grabbing at others, cursing, and resistant to care. The staff had established eye contact, called him by his name, explained the care they were doing, used simple sentences, offered to toilet him, offered fluids, and reapproached later. It is noted that behaviors worsened with these approaches.

A Behavior Sheet, dated 4/23/21 at 1:00 p.m., indicated he had displayed the behavior of severely yelling, screaming, and cursing at a staff member. Staff had attempted to approach in a calm manner, call him by name, talk with him,

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	05/19/2021

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

(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
	and reapproach later. The behavior had remained unchanged. He had told them to leave him alone and let him do what he wanted. A care plan, initiated on 4/24/21, indicated he had behavioral symptoms, such as urinating on the floor, yelling out, combativeness, cursing, calling staff names, and hitting staff due to his diagnosis of depression, insomnia, dementia, and delirium. The goal of the care plan, initiated on 4/24/21, was for his behavioral symptoms to be managed through care plan intervention. The interventions, initiated on 4/24/21, were to allow him to express his feelings, approach him from the front and make sure to have his attention, explain to him that his behavior was not appropriate, reapproach if he was refusing care, give his medications as ordered, provide mental health services as indicated, participate in his reality, and reassure/ offer comfort to him when he needed to calm down. A care plan, initiated on 4/24/21, indicated he had difficulty understanding others and making himself understood related to aphasia with a goal that he will be able to effectively communicate his wishes and understand others. The intervention included, but not limited to, reduce stimulation and background noise as necessary and allow me time to process information. A Behavior Sheet, dated 4/24/21 at 9:24 p.m., indicated he had begun severely hitting, kicking, pinching, scratching, spitting, yelling, screaming, resisting care, and cursing. The CNA (Certified Nursing Assistant) had attempted to do peri-care. He had become violent, and the CNA had walked away and reapproached him in an hour with a 2nd CNA. He continued to be violent with swinging, kicking, grabbing, and spitting at the 2 CNAs.			

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	05/19/2021

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

(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
	The Nurse had come in to attempt to calm him down. He would not calm down. He finally did calm down due to being exhausted and the CNAs were able to perform peri-care. A Behavior Sheet, dated 4/25/21 at 12:32 a.m., indicated he had displayed the behavior of severely resisting care, hitting, kicking, pinching, yelling, and screaming at staff. He had been sitting on the side of the bed naked and wet. He was approached by a CNA who attempted to do peri-care. He became violent. The nurse had attempted to talk with him, and he settled down. Again, they tried to do peri-care and he became violent. He was left alone and calmed down. They had attempted to stand him up and he became unsteady on his feet. A Behavior Sheet, dated 4/28/21 at 5:24 p.m., indicated he had hit staff, cursed, and been sexually inappropriate with staff during peri-care. He had "slapped" the CNA on the buttock during peri care. When she asked him to stop, he had used profanity at her. He had been left alone and reapproached later, which did not improve the behavior. A Behavior Sheet, dated 5/3/21 at 9:00 a.m., indicated he had severely yelled, screamed, and cursed staff members. There was no precipitating factor identified. Staff had attempted to approach in a calm manner, remove him from the situation, call him by his name and reapproach later. None of these interventions had decreased the behavior. When attempting to redirect him, he began yelling louder and getting ruder and more agitated. A Behavior Sheet, dated 5/4/21 at 12:53 a.m., indicated he had refused to allow the nurses to			

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	05/19/2021

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

(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
	complete a dressing change to his feet and started to kick his feet at them. They had attempted to break the task into small steps, and he had continued to refuse the dressing change. A Psychiatrist progress noted, dated 5/4/21, indicated he continued to display aggression at times and was combative during care. He had previously received 14 days of Haldol for delirium. The Haldol was restarted at 1 mg 2 x daily for delirium due to chronic kidney disease. The clinical record did not contain an IDT (Interdisciplinary Team) note or a behavior meeting note indicating the behaviors had been reviewed or that new non-pharmacological interventions had been reviewed. The behavior care plan, initiated 4/24/21, had not been updated with any new non-pharmacological interventions. During an interview on 5/13/21 at 11:12 a.m., CNA 29 and CNA 35 indicated that if Resident G's behaviors would increase when he was around a lot of other people or in a noisy environment. They found that trying to go very slow and easy with him helped. At times they would take him to his room, where it was quiet. He also responded well to getting him a soda. During an interview on 5/13/21 at 2:35 p.m., the SSD (Social Service Director) indicated that behaviors were reviewed in morning meeting to see if they are new or worsening. Based on the recommendation in the morning meeting, social services would then move forward with setting up suggested treatment or updating the care plan with interventions. The residents with behaviors were reviewed monthly with the psychiatric provider in the behavior meeting. Behavior meeting notes should be documented after the			

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	05/19/2021

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

(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
	behavior meeting. She did not have any behavior meeting notes for Resident G. During an interview on 05/14/21 at 10:52 a.m., FM (Family Member) 33 indicated that she had taken him to the podiatrist on 3/31/21. His toenails had been in bad shape and the Podiatrist had cut them. She had taken him back to the Podiatrist on 4/27/21 and she had recommended a doppler (circulation test) be done due to the open area on his toe. The Podiatrist had discussed the gangrene present in his foot with her. She had taken him to the vascular surgeon for the doppler exam, but they could not do the entire exam because it had caused him pain. He frequently complained of pain in his feet and if they were barely touched, he would go "crazy". He also had very ticklish feet. During an interview on 05/14/21 at 2:42 p.m., ST (Speech Therapist) 24 indicated his ability to understand what said to him and to express what he wanted was decreased. He would frequently tell her not to touch his toe, but she would be nowhere near his feet. He would ask to go the bathroom and then deny needing to use the bathroom when he got there. She believed that the expressive and receptive disorder, along with his dementia, made it difficult for him to understanding what was said to him and expressing needs he may have. His family member had expressed this was happening when she cared for him at home, but it had become worse after the stroke. He had made some progress and she was communicating with the staff to try to come up with new strategies to assist with his behaviors. 2. The clinical record for Resident O was			

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	05/19/2021

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

(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

reviewed on 5/12/21 at 2:24 p.m. The Resident's diagnosis included, but were not limited to, dementia and mood disorder.

The clinical record contained an Annual MDS (Minimum Data Set) Assessment, complete 3/3/21, which indicated she was severely cognitively impaired.

A care plan, last revised on 4/24/21, indicated she was at risk for elopement due to impaired cognition and wandering without a purpose. She had a history of eloping from the facility. The goal was for her to continue to respond to redirection during exit seeking episodes ad for her to not exit the building unattended. The interventions included, but were not limited to, offer snacks, provide one on one conversation, try to identify what she was searching for and assist her with addressing what I am missing.

A progress note, dated 5/5/21 at 2:56 p.m., indicated a door alarm had gone off and she was found sitting outside the door in her wheelchair.

An IDT (Interdisciplinary Team) note, dated 5/5/21 at 3:58 p.m., indicated she had exited the door on her hallway. The alarm had sounded, and the staff had located her outside the door in less than one minute from exiting. She had no injuries and her family and doctor had been notified. The door alarm had worked properly, and the incident was not a state reportable incident.

The IDT note did not indicate that the reason for her attempting to leave had been assessed.

An intervention of take resident to the bathroom frequently was added to the elopement care plan

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	05/19/2021

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

(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
	on 5/5/21. On 5/13/21 at 4:47 p.m., Resident O was observed sitting in her wheelchair behind the nurses' station with the nursing staff. She wheeled toward the hallway and asked what she needed to do. During an interview on 5/13/21 at 4:50 p.m., LPN (Licensed Practical Nurse) 36 indicated that the staff have her sit behind the nursing station so that they can keep an eye on her. She wandered at times and they liked to keep a close eye on her. On 5/17/21 at 3:46 p.m., She was observed sitting in her wheelchair by the medication cart in the hallway. QMA (Qualified Medication Aide) 37 was beginning to pass medications. She was wringing her hands and asked QMA 37 what she should do. QMA 37 spoke with her and she requested to use the bathroom. QMA 37 took her to the bathroom. During an interview on 5/17/21 at 3:57 p.m., QMA 37 indicated she tried to keep her close to her or where she could see her because she wandered at times. During an interview on 5/17/21 at 4:20 p.m. LPN 36 indicated that the there was no behavior management plans kept at the nurse's stations, only in the electronic chart. During an interview on 5/17/21 at 3:10 p.m., UM (Unit Manager) 4 indicated that after she was found outside the door on 5/5/21, 15-minute checks had been initiated, and that normally when she is wandering it is not exit seeking, but rather wandering with no purpose. They had attempted			

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	05/19/2021

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

(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
	to use an activity box for her, and it was unsuccessful. The staff attempted to keep her around them and socialized with her. The elopement risk care plan had not been updated with these interventions. On 5/13/21 at 11:55 a.m., the DON (Director of Nursing) provided the Behavior Management Policy, revised October 2019, which read "...Policy: To ensure the resident receives effective treatment and interventions for behavior and mood symptoms. To ensure the resident is receiving the necessary medication at the lowest effective dose to treat their symptoms. Procedure...2. The nurse or social service will complete the Behavior Sheet upon being notified of or witnessing a behavior...5. Social Services will complete follow-up documentation of behaviors under the progress notes...8. Social Services will complete a behavior assessment with the nursing department by completing the 'Behavior Management Team Review' prior to the end of the 2 week observation for all new and worsening behaviors and determine if a behavior management program is needed. 9. If a behavior management program is needed, SS {sic} will develop the Behavior Management Program and enter it into the EMR {sic} under care plans. A copy of the Behavior Management Program will be kept at the Nurse's Station to allow access to all Staff...12. A care plan will be initiated within 72 hours from the time the behavior occurs...14. Social Services will review behaviors daily Monday through Friday in the clinical meeting..." 3.1-37(a)			

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	05/19/2021

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

(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 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act 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			

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	05/19/2021

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

(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
	are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility failed to timely follow up on a pharmacy recommendation for 1 of 6 residents reviewed for unnecessary medications. (Resident D) Findings include: The clinical record for Resident D was reviewed on 5/12/21 at 10:00 a.m. The diagnoses included, but were not limited to, history of DVT (deep vein thrombosis.) The 4/2/21 pharmacy recommendation read, "Relevant meds [medications:] Eliquis 2.5 mg BID [twice daily,] aspirin 81 mg daily, clopidogrel 75 mg daily. Resident has no compelling indication listed on chart at this time for use of triple drug therapy. Initially admitted in November with DOAC [direct oral anticoagulant] alone; aspirin and Plavix added Dec [December] 2020 post-hospitalization for colitis. Aspirin/Plavix were listed as home meds on hospital paperwork which appears to be inaccurate based on available history. Use of triple drug therapy increases the risk of bleed events. Recommend evaluate current therapy and make changes as warranted to minimize risk of adverse consequences." The 4/27/21 physician response documented on the pharmacy recommendation read, "1. When was DVT 2. How many DVT." The 4/27/21 documentation by nursing on the bottom of the pharmacy recommendation read, "Noted by	F 0756	1. Additional medical records were again requested for resident D. Information was obtained from family and communicated to the physician and orders obtained. 2. All residents have the potential to be affected. Pharmacy reports from the previous month were reviewed and follow-up has been completed. 3. The Pharmacy Recommendations policy has been reviewed and no revisions necessary. The DON or her designee will audit recommendations within 14 days of receipt to ensure physician response. If additional information is requested, the DON or designee will ensure efforts to obtain information are made and documented in the medical record until completed. The audits will be completed monthly for 6 months to ensure 100% is achieved and maintained. 4. The findings of these audits will be reviewed during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/18/2021

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	05/19/2021

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

(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
	[name of Physician 25.] Need to obtain further info [information] on past hx [history] of DVT before making a change. Awaiting medical records request." There was no information in the clinical record to indicate follow up to the medical records request, and the May 2021 MAR (medication administration record) indicated Resident D was still receiving all 3 medications. An interview was conducted with the ADON (Assistant Director of Nursing) on 5/19/21 at 12:10 p.m. She indicated she spoke with Physician 25 today, and he was going to discontinue the Eliquis. They were waiting on medical records regarding Resident D's history of past DVTs, which were never received, and it wasn't follow up on until now. 3.1-25(i) This Federal tag relates to complaint IN00351434.			
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.			

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	05/19/2021

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

(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
	Based on observation, interview, and record review, the facility checked a resident's blood sugar without a physician's order to do so for 1 of 1 resident randomly observed. (Resident H) Findings include: The clinical record for Resident H was reviewed on 5/12/21 at 11:00 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis. Resident H's physician's orders did not include an order to check her blood sugar. An interview and observation was conducted with Resident H on 5/18/21 at 4:20 p.m. During the interview, QMA (Qualified Medication Aide) 12 entered the room at 4:26 p.m. QMA 12 informed Resident H she was there to check her blood sugar. Resident H asked QMA 12 if she was new to the facility. QMA 12 informed her she was from an agency. Resident H informed QMA 12 she did not normally get her blood sugar checked and asked QMA 12 if, perhaps, she was supposed to check her roommate's blood sugar, because he received blood sugar checks, but she did not. QMA 12 informed Resident H that the nurse at the desk told her to check the blood sugar of the female in the room. QMA 12 proceeded to check Resident H's blood sugar on her finger, announced it was 98, then left the room. Resident H had a shocked look on her face throughout the interaction with QMA 12. After QMA 12 left the room, Resident H indicated she hadn't had her blood sugar checked in months. An interview was conducted with LPN (Licensed Practical Nurse) 13 at the nurse's desk on	F 0773	1. Resident H's identity is known to the facility. Social services to follow-up with resident to ensure no mental anguish. 2. All residents have the potential to be affected. See below for corrective measures. 3. Staff will be educated on Resident's Rights. The DON or her designee will interview 10 random residents weekly as to whether staff are listening to them and no unnecessary treatments/labs are performed. Audits will continue for 4 weeks and until 100% compliance is achieved, then 10 residents per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented at the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	06/18/2021

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	05/19/2021

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

(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
	5/18/21 at 4:31 p.m. LPN 13 indicated she told QMA 12 to check the male's blood sugar in the room, not the female's. LPN 13 provided a small piece of paper with 6 room numbers with blood sugar results next to them, including Resident H's room with an F with a line through it to the left of Resident H's room number and a 98 to the right of Resident H's room number. The physician's orders for Resident H's roommate indicated to check his blood sugar daily one time a day for diabetes mellitus. An interview was conducted with the NC (Nurse Consultant) on 5/18/21 at 4:45 p.m. She indicated QMA 12 should have listened to Resident H, when she said she didn't get blood sugar checks. The Glucose Meter Cleaning & Testing policy was provided by the NC on 5/19/21 at 11:12 a.m. It read, "Obtaining blood sugar results: 1. Verify order." 3.1-49(f)(1)			
F 0880 SS=E 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			

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	05/19/2021

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

(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
	must include, at a minimum, the following elements: §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			

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	05/19/2021

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

(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
	(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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 observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 regarding utilizing hand hygiene and donning Personal Protective Equipment (PPE) in a resident's room that was in droplet precautions, to perform hand hygiene prior to administering medications, discard a medication which had fallen onto a medication cart, properly disinfect a blood glucose monitoring machine and wear disposable gloves when administering insulin for 2 of 2 residents reviewed for infection control and 5 of 6 residents reviewed for medication administration. (Resident X, U ,R, Y, Z, EE and FF) Findings include: 1. The clinical record for Resident X was reviewed on 5/11/21 at 11:15 a.m. The diagnoses included, but were not limited to: heart	F 0880	Creekside Health and Rehabilitation 3114 E 46th St Indianapolis, IN 46205 Survey Date May 19, 2021 Survey Event ID S4IY11 Deficiency F 880 The facility failed to failed to properly prevent and/or contain COVID-19 regarding utilizing hand hygiene and donning Personal Protective Equipment (PPE) in a resident's room that was in droplet precautions, to perform hand hygiene prior to administering medications, discard a medication which had fallen onto a medication cart, properly disinfect a blood glucose monitoring machine and wear disposable gloves when administering insulin for 2 of 2	06/18/2021

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	05/19/2021

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

(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
	failure and acute pancreatitis. The resident was admitted to the facility on 4/30/21. An Admission Minimum Data Set (MDS) dated 5/7/21, indicated Resident X was cognitively intact. A physician order dated 4/30/21 indicated Resident X was in droplet precautions for 14 days for admission precautions. A care plan for Resident X dated 5/3/21 indicated "I am in droplet isolation for observation of signs and symptoms of COVID-19 infection due to recent admission to the facility...Interventions...You will wear personal protective equipment as designated by the facility policy..." An observation was made of room tray deliveries on 5/11/21 at 12:12 p.m. Certified Nursing Assistant (CNA) 9 was observed wearing a surgical mask delivering meal trays to residents' rooms. At 12:29 p.m., CNA 9 was observed taking a meal tray into Resident X's room. The door had PPE supplies hanging over the door and a droplet precaution sign was hung on the side. CNA 9 was not observed donning on gown, gloves, N95 respirator, or eye protection prior to entering the resident's room. She then left the room and walked off the unit. There was no observation of CNA 9 utilizing hand hygiene after she exited the room. CNA 9 returned to the unit and delivered spinach to Resident X in the room. She had not donned on gown, gloves, N95 respirator, or eye protection prior to entering the resident's room. She then exited the room. At that time, she was not observed utilizing hand hygiene after she exited the room. CNA 9 then returned back to Resident X's room with License		residents reviewed for infection control and 5 of 6 residents reviewed for medication administration. **Root cause analysis** **Finding 1)** What: Staff incorrectly or just not donning and doffing PPE when entering yellow rooms. Why: Each of them stated they knew they had done it wrong or just forgot. Immediate corrective action: Staff mentioned were instructed not to enter a yellow or red room without donning the PPE as directed and listed out on the sign on the door. **Finding 2)** What: Hand Hygiene not completed with medication pass or following doffing gloves. Why: Staff states either they knew they did it wrong or they just forgot. Immediate corrective action: Staff mentioned were instructed on Hand Hygiene. **Finding 3)** What: Staff did not discard a pill that landed on a piece of paper lying on top of the medication cart. Instead, he went on to administer that pill. Why: His rationale was that if it had landed on the top of the cart, he would have considered it dirty and disposed of it, but since it landed on the paper it was still clean. Immediate corrective action: Staff	

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	05/19/2021

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

(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
	Practical Nurse (LPN) 2 with a cup of water. LPN 2 was observed instructing CNA 9 what PPE to wear into Resident X's room. During that time, Resident X indicated "you have to put that on now? No one has ever used that stuff before. 2 days left of quarantine and now you guys are putting that stuff on?" An interview was conducted with CNA 9 on 5/11/21 at 12:39 p.m. She indicated she had forgotten to don the PPE prior to entering Resident X's room. 2. The clinical record for Resident FF was reviewed on 5/13/21 at 4:56 p.m. The Resident's diagnosis included, but were not limited to, anemia and hypertension. On 5/13/21 at 4:56 p.m., LPN (Licensed Practical Nurse) 28 was observed administering medications to Resident FF. He did not perform hand hygiene prior to preparing the medications. He removed a dose pack, containing 3 pills, from the medication cart and opened it. He poured the medication into a plastic medication cup. One of the pills fell onto a piece of paper laying on the medication cart. He looked in the medication cup and realized one of the medications was not there, located it on the piece of paper and picked it up with his bare hand and placed it into the medication cup. He then entered the room and administered the medication to her. During an interview on 5/13/21 at 5:20 p.m., LPN 28 indicated that during medication pass, he was to perform hand hygiene prior to entering a room and after leaving a resident's room. If a medication fell onto the medication cart it should be discarded. The pill that he had picked up and administered had not fallen on the		mentioned were educated on medication pass procedures. **Finding 4)** What: Staff did not clean a glucometer appropriately. Why: She only cleans it after 2 people use it and she thinks the alcohol prep does a better job than the approved wipe. Immediate corrective action: She was educated on the glucometer cleaning policy. **Finding 5)** What: A nurse did not don gloves prior to administering insulin. Why: She forgot. Immediate corrective action: She was educated on the need to don gloves due to potential exposure to blood-borne pathogens. **Corrective measures** Reeducation and inservices with staff including: Isolation procedures for COVID, Hand hygiene, Medication Administration, Glucometer Cleaning, Glove Use Summary: Root cause analysis determined the need for daily observations and continual re-education by the IP and facility administration. Continued non-compliance will result in disciplinary action and possible termination to protect residents and staff. Competencies on donning/doffing PPE, hand hygiene, and glucometer cleaning to be	

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	05/19/2021

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

(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
	medication cart, it had fallen on the piece of paper, so he went ahead a gave it. 3. The clinical record for Resident R was reviewed on 5/17/21 at 5:09 p.m. The Resident's diagnosis included, but were not limited to, cerebral palsy and aphasia. On 5/13/21 at 5:09 p.m., LPN (Licensed Practical Nurse) 28 was observed administering medications to Resident R. He did not perform hand hygiene prior to preparing the medication. He poured 10 ml of Keppra (seizure medication) into a medication cup. He then poured the Keppra into a glass of water. He entered the room and set up his supplies on the bedside table, no hand hygiene was performed, he put on a pair of disposable gloves, turned off the continuous feeding pump and disconnected the gastrostomy tube from the feeding. He inserted a piston syringe into the gastrostomy tube and poured the mixture of water and medication into the piston syringe. He then inserted the plunger into the piston syringe and slowly pushed the water and medication mixture into the gastrostomy tube, disconnected the piston syringe from the gastrostomy tube and replaced the continuous feeding tube into the gastrostomy tube and restarted the feeding pump. He did not flush the gastrostomy tube with water prior to reattaching the feeding. He then removed his disposable gloves and left the room without performing hand hygiene. During an interview on 5/13/21 at 5:20 p.m., LPN 28 indicated this was how he normally gave Resident R's medication. 4. The clinical record for Resident Y was reviewed on 5/17/21 at 9:21 a.m. The Resident's		completed with nursing staff. Daily rounding, varying shifts and days, will be conducted by the IP or designee using the Infection Control Patient and Staff Surveillance tool to continue for a period of six weeks and until 100% compliance is achieved then two times weekly for a period of at least 6 months and compliance is maintained to be determined by the QAPI Committee. The Facility LTC infection control self-assessment was reviewed with the regional IP it was agreed that it is an accurate assessment of the facility. Survey findings, root cause analysis reviewed with regional IP, Medical Director, Administrator, facility IP, and Director of Clinical Services. The plan of action was agreed upon.	

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	05/19/2021

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

(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
	diagnosis included, but were not limited to, anemia. On 5/17/21 at 9:21 a.m., LPN 2 was observed administering medications to Resident Y. She did not perform hand hygiene and donned a pair of disposable gloves. She then obtained his medications from the medication cart and poured them into a plastic medication cup. She removed her disposable gloves, did not perform hand hygiene and put on a new pair of disposable gloves. She entered his room and gave him his medications. She then returned to the medication cart and removed the disposable gloves. During an interview on 5/15/21 at 10:49 a.m., LPN 2 indicated she should have performed hand hygiene prior to donning and after doffing disposable gloves. 5. The clinical record for Resident Z was reviewed on 5/17/21 at 4:05 p.m. The Resident's diagnosis included, but were not limited to, diabetes. On 5/17/21 at 4:05 p.m., QMA (Qualified Medication Aide) 37 was observed performing a blood sugar check for Resident Z. She removed the blood glucose machine from the medication cart. She performed hand hygiene and then took her supplies and entered the room. She performed hand hygiene again, and donned disposable gloves. She cleansed her finger using an alcohol pad, performed the blood glucose check, doffed her disposable gloves and performed hand hygiene prior to leaving the room. During an interview on 5/17/21 at 4:14 p.m.,			

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	05/19/2021

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

(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
	QMA 37 indicated she had not cleansed the blood glucose monitor prior to using it for Resident Z. She routinely did 2 resident's blood glucose tests before she cleansed the blood glucose monitor. She was then observed to clean the monitor using an alcohol swab. She produced a Sani-Wipe from the medication cart. She indicated she preferred to use the alcohol swab because she thought it did a better job. 6. The clinical record for Resident EE was reviewed on 5/18/21 at 11:15 a.m. The Resident's diagnosis included, but were not limited to, diabetes. On 5/18/21 at 11:15 a.m., LPN 10 was observed administering insulin to Resident EE. She performed hand hygiene and donned disposable gloves. She drew up the insulin in an insulin syringe and then removed her gloves. She took the syringe of insulin and an alcohol pad into his room. She performed hand hygiene and administered the insulin into his abdomen. She then performed hand hygiene and left the room. She did not don disposable gloves prior to administering the insulin During an interview on 5/18/21 at 11:20 a.m., LPN 10 indicated she should have worn disposable gloves while administering the insulin. 7. A random observation was made on 5/12/21 at 2:33 p.m., of the 300 unit hallway. LPN (Licensed Practical Nurse) 2 was exiting from Resident U's room. Resident U's room was clearly marked as a Contact/Droplet precautions room with signage. LPN 2 was not wearing a N95 facemask, but rather, she wore a surgical mask pulled down below her nose.			

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	05/19/2021

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

(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

The clinical record for Resident U was reviewed on 5/12/21 at 2:46 p.m. Resident U's diagnoses included, but not limited to, chronic embolism and thrombosis of unspecified vein, hypertension, diabetes type II, and chronic obstructive pulmonary disease. Resident U was admitted to the facility on 5/3/21. Resident U had not received the COVID-19 vaccine, nor had she contracted COVID -19 in the last 90 days.

An interview with LPN 2 was conducted on 5/12/21 at 2:33 p.m., which was the same time as the observation was made. LPN 2 indicated; she had not worn a N95 facemask when in Resident U's room even though Resident U was on contact/droplet precautions related to being recently admitted to the facility with an unknown COVID-19 status.

An interview with NC (Nurse Consultant) was conducted on 5/19/21 at 2:28 p.m. She indicated the facility follows CDC (Centers for Diseases and Controls) recommendations regarding quarantine for new or readmissions with unknown COVID -19 status. She further stated the facility also follows the State of Indiana toolkit for new/readmissions to the facility.

A Personal Protective Equipment (PPE) policy was provided by the Nurse Consultant on 5/19/21 at 2:28 p.m. It indicated "...Policy: It is the policy of this facility to ensure PPE is available to staff, residents and visitors as needed; and they understand when and how to use the PPE. Purpose: To prevent transmission of infectious illnesses or pathogens...9. staff will follow the policy for isolation precautions and the use of PPE.

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	05/19/2021

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

(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
	The Indiana State Department of Health's Long-term Care Facilities Guidelines in Response to COVID-19 Vaccination, last updated 3/16/21, stated, "Unknown COVID-19 Status: CDC recommends facilities create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. CDC allows for options that may include placing the resident in a single-person room in the general population area or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents can be transferred out of the observation area to the general population area of the facility if they remain without a fever and without symptoms for 14 days after their exposure (or admission)... All recommended PPE [sic, personal protection equipment] should be worn during care of newly admitted or readmitted residents under observation for unknown COVID status; this includes use of face mask, eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves and gown. Cloth face coverings are not considered PPE and should not be worn by healthcare providers when PPE is indicated...New residents requiring 14-day quarantine could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission)..." 3.1-18(b)(1) 3.1-18(l)			