| | PROVIDER OR SUPPLIE | TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155628 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | |
|--------------------------|--|--|--------------------|--|---|-------------------------|
| (X4) ID PREFIX TAG | IDE HEALTH AND | | 311 | EET ADDRESS, CITY, STATE, ZIP CC 4 EAST 46TH STREET | DD | |
| PREFIX TAG | | REHABILITATION CENTER | INC | IANAPOLIS, IN 46205 | | |
| 0000 | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION | ID PREFI TAG | CROSS-REFERENCED TO THE AP | DULD BE COM | (X5) PLETION DATE |
| 0000 | | | | | | |
| 8ldg. 00 | REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for the Investigations of Complaints IN00402786, IN00388819 and IN00400626. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00402786 - No deficiencies related to the allegations are cited. Complaint IN00388819 - No deficiencies related to the allegations are cited. Complaint IN00400626 - Federal/state deficiencies related to the allegations are cited at F745. Survey date: March 14, 2023 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Census Bed Type: SNF/NF: 110 Total: 110 Census Payor Type: Medicaid: 86 Other: 15 Total: 110 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 17, 2023 | | F 0000 | The completion of this correction does not co an admission that the deficiency exists. The correction is provided evidence of the facilitie to comply with the reg and continue to provid care in a safe environm The facility is requestin review for compliance. | nstitute alleged plan of as es desire ulations le quality nent. ng a desk | |
| 0745 SS=D | | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 04/19/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE C A. BUILDING | onstruction (| (X3) DATE SURVEY COMPLETED 03/14/2023 | |
|---------------|--|--|--------------------------------|--|---|--------------------|
| | | 155628 | B. WING | | | |
| | PROVIDER OR SUPPLIE | R REHABILITATION CENTER | 3114 E | ADDRESS, CITY, STATE, ZIP COD EAST 46TH STREET NAPOLIS, IN 46205 | | |
| (X4) ID | I | STATEMENT OF DEFICIENCIE | ID | | | (X5) |
| PREFIX TAG | (EACH DEFICIE) | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | COMPLETION DATE |
| Bldg. 00 | §483.40(d) The famedically-related maintain the high mental and psych resident. Based on observative review, the facility health services bet 3 residents review and ensure residen dental services tim for dental services. Findings include: a) The clinical new included, but were with depression and the facility on 12/1 The depression car of having signs and loss of interest in a sleeplessness, and his depression symhis care plan intervere every his medicar receive/participate ordered/needed. The antidepressant indicated he was and to his use of antide was for him to havus use of his medicat and psychological to receive his medicat to report and the family of the family of | acility must provide social services to attain or lest practicable physical, hosocial well-being of each ion, interview, and record failed to coordinate mental ween facility providers for 1 of ed for mental health services ts received recommended ely for 2 of 3 residents reviewed . (Resident B and Resident D) record for Resident B was 23 at 11:20 a.m. His diagnoses not limited to, mood disorder d insomnia. He was admitted to | F 0745 | The facility requests IDR for thi citation as it feels it has made every good faith effort to meet a requirement. The facility will ensure this requirement is met through the following corrective measures: 1. Resident B did see the oral surgeon of his choice for consultation. He failed to list th facility on his HIPPA release so the office will provide the facility with no information. Per the resident, he will be scheduling next appointment in the next fe weeks and let the facility know when that is. Has psychiatric medications remain as directed psychiatric services and the facility NP has agreed to participate in the next GDR meeting, either in person or otherwise. Resident D has her oral surgery consultation scheduled for 3/27/23 and the facility will be prepared to transport as back-up in the event the state-approved transportati vendor does not show or decid to leave without the resident. 2. All residents receiving psychiatric services were review to ensure recommended medication(s) and dosage(s) and place and no concerns were | this ne by his w d by d by en on es wed | 04/05/2023 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VPRQ11 Facility ID: 009569

If continuation sheet Page 2 of 16

| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155628 | | (X2) MULTIPLE CC A. BUILDING B. WING | DNSTRUCTION C 00 | (X3) DATE SURVEY COMPLETED 03/14/2023 | |
|--------------------------|---|---|--|--|--|--|
| | PROVIDER OR SUPPLIE SIDE HEALTH ANE | R REHABILITATION CENTER | 3114 E/ | ADDRESS, CITY, STATE, ZIP COD AST 46TH STREET APOLIS, IN 46205 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) noted. All residents were review | DATE | |
| | "Writer met with r has a diagnosis of why he is not on a explained that it ap for mood and traze states that he was help with smoking Resident states that and everyone else feels that he shoul resident was havin mood changes. Re sleeping well and a diagnosis of dep any other mood co well and if there at be exacerbating sy don't know, I'm ju denies any though the remark "If I we they would treat th depression. Just be self, everyone feel advised that Nursi [psychiatric/psych notified. Resident psych services as a counseling a servio The 1/23/23 psych 'I get more and mo [History of Presen this date. Patient w and upset he was r was still initially in | e note read, "Chief Complaint: ore depressed by the day.' HPI t Illness:] Patient is seen on oiced that he was depressed of on anti-depressant. Patient n denial that Wellbutrin is for the admitted being on a | | to determine if all necessary dental consultation has been provided and all are up to date. 3. The policy regarding Ancillar Services was reviewed and no changes are indicated. Nursing staff will be educated on this policy. Facility staff were alerte to ensure phone volume is not muted. The HFA or her designe will review 5 residents per week determine if any dental or psychiatric services have made recommendations and ensure follow-up is complete. This will continue weekly for 6 weeks an until 100% compliance is achieved, then 5 per month for months and until 100% compliance is maintained. Additionally, the HFA or her designee will call the facility 5 random times weekly, after nom business hours, to ensure staff answer timely and phone is not set on mute. This will continue weekly for 6 weeks and until 10 compliance is achieved, then 5 month for 6 months and until 100% compliance is maintained. 4. The findings of these audits be presented during the facility ⁵ QAPI meetings and the plan of action adjusted accordingly. | ry d ee c to d 6 mal 0% per t. will s | |

PRINTED: 04/19/2023 FORM APPROVED

| STATEME | T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION | | | | | | E SURVEY |
|---------|---|-----------------------------------|------|----------|---|------------|----------|
| | OF CORRECTION | IDENTIFICATION NUMBER | | UILDING | <u>00</u> | · · · | PLETED |
| | OF CORRECTION | 155628 | B. W | | 00 | 03/14/2023 | |
| | | | | CTDEET A | DDDEGG OFTV OT ATE ZID OOL | | |
| NAME OF | PROVIDER OR SUPPLIEF | R | | | IDDRESS, CITY, STATE, ZIP COE AST 46TH STREET |) | |
| CREEK | SIDE HEALTH AND | REHABILITATION CENTER | | | APOLIS, IN 46205 | | |
| X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORREC | CTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP | JLD BE | COMPLET |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | - | patient being limited on | | | | | |
| | | ations due to his chronic | | | | | |
| | | his provider discussed | | | | | |
| | - | in only at this time. Patient did | | | | | |
| | - | gher dose of this medication in | | | | | |
| | | it was reduced at a hospital | | | | | |
| | | Patient was receptive to | | | | | |
| | | in at this time. This provider | | | | | |
| | - | patient to work on healthy | | | | | |
| | | ioral interventions to work on | | | | | |
| | improving his depr | | | | | | |
| | | itrin XL 300 mg qd [every day.] | | | | | |
| | | XL (not SR or regular) 450 mg | | | | | |
| | | Monitor for progress and | | | | | |
| | | ects. Provide psychoeducation, | | | | | |
| | supportive therapy | and reassurance." | | | | | |
| | The physician's ord | ers indicated the Wellbutrin | | | | | |
| | was increased from | 300 mg qd to 450 mg qd, | | | | | |
| | effective 1/24/23. | | | | | | |
| | The 1/25/23 physic | ian note, written by Physician | | | | | |
| | 12, indicated Resid | ent B was being seen due to | | | | | |
| | complaints of wors | ening of his depression, with a | | | | | |
| | history of depression | n for 10 years. He was | | | | | |
| | currently on Wellbo | itrin, but Resident B did not | | | | | |
| | think it was helpful | . The assessment and plan | | | | | |
| | section of the note | ndicated safety measures | | | | | |
| | were addressed and | would refer to psyche for his | | | | | |
| | depressive disorder | | | | | | |
| | The 1/26/23 NP (nu | urse practitioner) note, written | | | | | |
| | | Resident B was being seen | | | | | |
| | | r depression. Psych recently | | | | | |
| | | utrin to 450 mg daily, but | | | | | |
| | | l it was not effective for him | | | | | |
| | - | prescribed for smoking | | | | | |
| | | ession. He reported his mother | | | | | |
| | | Prozac. Resident B was | | | | | |
| | | the increased dose of | | | | | |

| | NT OF DEFICIENCIES | x1) provider/supplier/clia identification number 155628 | A. 1 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | | (X3) DATE SURVEY COMPLETED 03/14/2023 | |
|--------------------------|---|---|---|--|--|----------|---|--|
| | PROVIDER OR SUPPLIE | REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP COD 3114 EAST 46TH STREET INDIANAPOLIS, IN 46205 | | | OD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY) | IOULD BE | (X5) COMPLET DATE | |
| | improvement in m for him. Resident i disturbances. The the note indicated Resident B was en of Wellbutrin 2 wo was following him The 2/2/23 NP not Resident B was se depression. Reside dose of Wellbutrin was frustrated bec Wellbutrin and wo antidepressant. He both took Prozac w depression and sle assessment and pla for his depression back to 300 mg qd that psych was fol The physician's or indicated the Well 450 mg qd to 300 Prozac 20 mg qd w The 2/9/23 NP not Resident B was se depression. Reside been the best in se continue the taper and plan section o depression to decr mg qd for 7 days, continue the Proza | te, written by NP 13, indicated en for an acute visit for ent B reported his increased n was not effective for him and ause he did not want to be on buld like a different e reported his mother and sister with great efficacy. He reported ep disturbances. The an section of the note indicated to decrease the Wellbutrin XL d; to start Prozac 20 mg qd; and lowing him. ders and February, 2023 MAR butrin XL was decreased from mg qd, effective 2/3/23 and | | | | | | |

| CNTERS FO STATEME | T OF HEALTH AND HU R MEDICARE & MEDI NT OF DEFICIENCIES OF CORRECTION | | . , | ILDING | DNSTRUCTION | | RM APPRO B NO. 0933 SURVEY ETED |
|----------------------|--|---|-----|--|---|---|--|
| | PROVIDER OR SUPPLIE | R REHABILITATION CENTER | | 3114 E | ADDRESS, CITY, STATE, ZIP COD AST 46TH STREET IAPOLIS, IN 46205 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X. |
| PREFIX | (EACH DEFICIE | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH | | E | COMPLE |
| TAG | REGULATORY C | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DAT |
| | 1 5 | ders indicated to administer 150 | | | | | |
| | mg of Wellbutrin | XL starting 2/10/23 with a | | | | | |
| | discontinue date o | f 2/9/23. The February, 2023 | | | | | |
| | MAR indicated he | received his last 300 mg dose | | | | | |
| | of Wellbutrin XL | on 2/9/23 and no Wellbutrin XL, | | | | | |
| | starting 2/10/23. | | | | | | |
| | The 2/13/23 NP no | ote, written by NP 13, indicated | | | | | |

PRINTED: 04/19/2023 RM APPROVED

B NO. 0938-039

| | SIDE HEALTH AND REHABILITATION CENTER | | IAPOLIS, IN 46205 | |
|--------------------------|---|---------------------|--|------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | |
| TAG | The physician's orders indicated to administer 150 mg of Wellbutrin XL starting 2/10/23 with a discontinue date of 2/9/23. The February, 2023 MAR indicated he received his last 300 mg dose of Wellbutrin XL on 2/9/23 and no Wellbutrin XL, starting 2/10/23. The 2/13/23 NP note, written by NP 13, indicated Resident B was seen for an acute visit for depression and pain management. He was recently started on Prozac and also on a taper off of Wellbutrin. he reported significant improvement with Prozac and again requested his Prozac dose be increased. The assessment and plan section of the note indicated for his depression to decrease the Wellbutrin XL 150 mg qd for 7 days, then discontinue; to continue the Prozac at 20 mg qd and consider an increase next week; and that psych was following him. The physician's orders regarding the Wellbutrin XL did not change from 2/9/23, as he continued to no longer receive the medication. The February, 2023 MAR indicated he received his last 20 mg administration of Prozac on 2/13/23, and began receiving 30 mg of Prozac qd, starting 2/14/23. The 2/20/23 NP note, written by NP 13, indicated Resident B was seen for an acute visit for depression and congestion. He reported noticing significant improvement with Prozac as "it was | TAG | DEFICIENCY) | DATH |
| | increased to 30 mg last week." The assessment and plan section of the note indicated for his depression to continue Prozac 30 mg qd and that psych was following him. | | | |
| | The 2/22/23 social services behavior note read, "Description of the behavior: Resident was yelling at staff, threw pills, and was difficult to redirect last evening. Resident was upset about missed | | | |

| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155628 | r í | JILDING | 00 | CC | (X3) DATE SURVEY COMPLETED 03/14/2023 | |
|---------|----------------------|---|-----|---------|--|-------------|---|--|
| | PROVIDER OR SUPPLIE | D REHABILITATION CENTER | | 3114 E/ | ADDRESS, CITY, STATE, ZIP C AST 46TH STREET APOLIS, IN 46205 | COD | | |
| (X4) ID | SUMMARY | Y STATEMENT OF DEFICIENCIE | | ID | | DECTION | (X5) | |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A | HOULD BE | COMPLETIC | |
| TAG | REGULATORY C | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | APPROPRIATE | DATE | |
| | dental appointmen | t and feeling that staff is not | | | | | | |
| | | d symptoms. Resident ordered | | | | | | |
| | - | inter] meds [mediations] online | | | | | | |
| | - | bill prior to obtaining MD order. | | | | | | |
| | - | t for details. Root Cause of | | | | | | |
| | | upset about dental appt | | | | | | |
| | | had feelings that nothing was | | | | | | |
| | | his cold symptoms. Resident | | | | | | |
| | | s] of depression and had recent | | | | | | |
| | | ication changes. Intervention: | | | | | | |
| | | redirect by educating resident | | | | | | |
| | - | orders, staff attempted to reason | | | | | | |
| | - | ed him to calm down, offered | | | | | | |
| | | as difficult to redirect. Resident | | | | | | |
| | | his room and calmed down after | | | | | | |
| | | reproached by staff. Outcome | | | | | | |
| | | esident was seen by NP on 2/20 | | | | | | |
| | | ase was ordered. MD and Psych | | | | | | |
| | | f behaviors on 2/20/23. Mucinex | | | | | | |
| | | nd psych services to see | | | | | | |
| | | sit on 2/23/23. Dental appt was | | | | | | |
| | | 23 - facility to transport | | | | | | |
| | resident. | 25 - facility to transport | | | | | | |
| | Staff to continue to | o monitor " | | | | | | |
| | Stall to continue to | o monitor. | | | | | | |
| | The 2/23/23 psych | note read, " Patient is seen | | | | | | |
| | | isit per staff request. Patient | | | | | | |
| | | 23Since our last visit, the PCP | | | | | | |
| | | vsician] NP made major | | | | | | |
| | | ication changes that were | | | | | | |
| | | eam and staff members. Patient | | | | | | |
| | | of chronic depressive symptoms | | | | | | |
| | - | t is limited on psychotropic | | | | | | |
| | · · | es due to his medical concerns. | | | | | | |
| | - | y focused on his on Wellbutrin. | | | | | | |
| | | itly decreased and discontinued | | | | | | |
| | | outrin within 7 days. The patient | | | | | | |
| | - | vas discontinued. He said he | | | | | | |
| | | | | | | | | |
| | | ing adjusted' only. Patient was | | | | | | |
| | aware of the new l | Prozac order. PCP NP started | | | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | x1) provider/supplier/clia identification number 155628 | (X2) MULTIPLE CO A. BUILDING B. WING | DNSTRUCTION 00 | CON | (X3) DATE SURVEY COMPLETED 03/14/2023 | | |
|---|--|---|--|---|----------|---|--|--|
| NAME OF PROVIDER OR SUPPLIER CREEKSIDE HEALTH AND REHABILITATION CENTER | | | 3114 E | ADDRESS, CITY, STATE, ZIP C AST 46TH STREET IAPOLIS, IN 46205 | OD | | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A | HOULD BE | (X5) COMPLETI | | |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE | | |
| | to 30 mg po qd w having significant time. He has been symptoms for quit are also chronic order restarted. Th not appropriate for increased too quic issues, insomnia a [hemoglobin/sodiu receptive to discon medicationDept Anhedonia [lack o Mood: irritable, a swings. Anxiety: thoughtsSleep: asleep, problems s Issues: verbal agg aggressionPatie argumentative and yesterday. These b himWellbutrin 1 discontinued this n This was not know teamPCP NP sta and increased it agg 2/13/23. These or this team until yes NOTE ON THE P PROVIDERS SHO MEDICATION C [name of psych pr Discontinue Proza dosing/side effect Prozac 20 mg po c discontinue. Patien | ession: depressed mood, f pleasure], self isolating. ngry, easily provoked, mood persistent worrying, ruminating chronic issues, problems falling taying asleep. Behavioral ression, gestures of at has been angry, even threw a cup at staff ehaviors are abnormal for XLPCP NP decreased and nedication earlier this month. In to the patient or this art Prozac at 20 mg qd on 2/3/23 gressively to 30 mg qd on ler changes were not known by terdayPlan: 1) PLEASE ATIENT'S CHART THAT NO DULD MAKE PSYCHOTROPIC HANGES UNLESS IT IS AN povider] PROVIDER. 2) c 30 mg po qd due to excessive risk/mood concerns. 3) Start d X [times] 3 days and then at understood and agreed to | | | | | | |
| | 300 mg (not 450 m | ange. 4) Resume Wellbutrin XL ng) po qd for depression at this s his Wellbutrin resumed. 5) | | | | | | |

| AND PLAN | NT OF DEFICIENCIES | x1) provider/supplier/clia identification number 155628 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | (X3) DATE COMPL 03/14/ | ETED |
|--------------------------|---|---|--|---|------------------------------|---------------------------|
| | PROVIDER OR SUPPLII | ER D REHABILITATION CENTER | 3114 E | ADDRESS, CITY, STATE, ZIP COD AST 46TH STREET APOLIS, IN 46205 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY) | | (X5) COMPLETIC DATE |
| | medication chang until his lab result of Wellbutrin is n progress and med psychoeducation, reassurance." The February, 202 XL was restarted Prozac was decreat on 2/24/23. An interview was Services Assistant indicated her undo situation was that Wellbutrin was "s and he was having thought nursing w care between psyc care providers. Th dose reduction) m going to start havit attending, so that the same page." It was the plan move with next month's The Medically Re was provided by H 3/14/23 at 1:03 p. Social Service goal for special popula Residents11. Co service needs to o coordinating effort | elated Psychosocial Needs policy ED (Executive Director) 1 on m. It read, "Medically related als:10. Provision of services tionc. Mentally ill ommunicating residents' social ther disciplines and ts to meet those needs. 12. ial service plan in the resident's | | | | |

PRINTED: 04/19/2023 FORM APPROVED

| | NT OF DEFICIENCIES | x1) provider/supplier/clia identification number 155628 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | COM | (X3) DATE SURVEY COMPLETED 03/14/2023 | |
|--------------------------|---|--|---|---|--------|---|--|
| | PROVIDER OR SUPPLIE | R REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP COD 3114 EAST 46TH STREET INDIANAPOLIS, IN 46205 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | |
| | reviewed on 3/14/2 included, but were with depression an the facility on 12/1 The 10/11/22 dent provider, indicated root. It read, "Doct distal decay, nonre hurt all the time ar and a denture place for extractions. En for a limited exam - broken tooth; Lo currently taking O medicine for this c problem for a few treatment was reco | record for Resident B was 23 at 11:20 a.m. His diagnoses not limited to, mood disorder d insomnia. He was admitted to 9/21. al note, from the facility's dental the had decay and a retained fors note Tooth #5 has gross storable. Patient states teeth d he would like them removed ed. Left a referral at the home mergency Exam Patient presents with discomfort; Probable cause cation - lower. Patient is TC [over the counter] pain ondition. Area has been a days. The following course of mmended - Extraction." | | | | | |
| | "Referral to oral su facility dental prov Writer submitted of surgeon provider.] referral if office ha The 12/22/22 socia transportation com resident's schedule | argeon was given by [name of rider] during 10/11/22 visit. Inline referral to [name of oral Writer to call to follow up on as not called by next week." Al services note read, "[Name of pany] did not show for d appointment today. Writer | | | | | |
| | spoke with [name surgeon provider] rescheduled for 2/ The 2/10/23 social called [name of tra with [name of tran member] - transpo | of staff member from oral - appt [appointment] was | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VPRQ11 Facility ID: 009569

If continuation sheet Page 10 of 16

| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155628 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED 03/14/2023 | | |
|--------------------------|---|--|--|---|---|----------------------------|--|
| | PROVIDER OR SUPPLIE | REHABILITATION CENTER | STREET A 3114 E INDIAN | | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| | became upset this his dentist appoint sheet dated 2/21/2 the reason he was appointment woul would attempt to r oral surgeon's offi Writer called [nam spoke with [name member,] she state error on [name of It appears that dup 2/15 and 2/16 and canceled both date [Name of transpor apologized for the The 2/22/23 social called [name of ar with [name of den to a cancellation th office tomorrow a states that MD ma tomorrow if medic deemed safe - [Na number to send in resident this AM a dental provider] he tomorrow morning rather make an app different dental pr previously. Reside could be done in t seen by [name of p addressed resident preferred dentist. I he could only see | I services note read, "Resident evening related to not going to ment last week (see behavior 3). Writer assured resident that unable to go to the d be investigated and writer reschedule again in the AM as ce is closed for the evening. ne of transportation company] of transportation company staff es that there was a scheduling transportation company's] end. olicate transport was made on the rep [representative] es rather than just the duplicate. tation company's staff member] inconvenience." I services note read, "Writer tother dental provider,] spoke tal provider's staff member] due here is an appointment in the t 10am. [Name of staff member] y do extractions in office cal records are reviewed and it is me of staff member] provided fax fo [information.] Writer met with and informed him that [name of as an appointment available g. Resident stated that he would pointment with [name of ovider] as he was seen there ent is not sure if extractions he office but would like to be provider] anyway. Writer also thaving the right to see his Resident stated that he thought [name of facility dental advised that [name of facility | | | | | |

| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155628 | A. BUI | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING | | CON | (X3) DATE SURVEY COMPLETED 03/14/2023 | |
|---------|---|---|--------|--|---|-------|---|--|
| | PROVIDER OR SUPPLIE | BR D REHABILITATION CENTER | | 3114 EA | DDRESS, CITY, STATE, ZIP COD AST 46TH STREET APOLIS, IN 46205 | - | | |
| (X4) ID | SUMMAR | Y STATEMENT OF DEFICIENCIE | | ID | | | (X5) | |
| PREFIX | (EACH DEFICIE | NCY MUST BE PRECEDED BY FULL | I | REFIX | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF | LD BE | COMPLETI | |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION | | | TAG | DEFICIENCY) | | DATE | |
| | dental provider] c | are is usually convenient for | | | | | | |
| | residents as they w | isit the facility for routine care | | | | | | |
| | but resident has th | e option to see his preferred | | | | | | |
| | | es. Resident has not asked to | | | | | | |
| | see another dentis | t in the past. Writer offered to | | | | | | |
| | | ity dental provider] to end dental | | | | | | |
| | - | ue routine care with his | | | | | | |
| | preferred dentist. | Resident stated that he wanted | | | | | | |
| | to leave [name of | facility dental provider] dental | | | | | | |
| | care in place and a | also see [name of another dental | | | | | | |
| | provider] to review | w her recommendations for oral | | | | | | |
| | surgery. Writer ca | lled [name of other dental | | | | | | |
| | provider] - spoke | with name of other provider's | | | | | | |
| | staff member] she | states [name of dental provider] | | | | | | |
| | has availability on | 3/2/23 @ 8am. Rep states that | | | | | | |
| | [name of dental pr | ovider] does some extractions in | | | | | | |
| | office but also ma | y referral out if necessary. Rep | | | | | | |
| | requested that den | tal referral information be faxed | | | | | | |
| | to [dental provider | r's fax number.]" | | | | | | |
| | | l services behavior note | | | | | | |
| | | appointment was scheduled for | | | | | | |
| | | ility was to transport the | | | | | | |
| | resident there. | | | | | | | |
| | | conducted with Resident B on | | | | | | |
| | - | m. He indicated his tooth "hurts | | | | | | |
| | | pointed to a tooth on the | | | | | | |
| | | of his mouth. He was unsure | | | | | | |
| | | th it was. Transportation did not | | | | | | |
| | | s December, 2022 or his | | | | | | |
| | | pointments, and the 3/2/23 | | | | | | |
| | | not confirmed by the facility. He | | | | | | |
| | | appointment, but when he | | | | | | |
| | | ld the facility did not confirm the | | | | | | |
| | | needed rescheduled. He | | | | | | |
| | | e had to wait 2 months, twice, | | | | | | |
| | | bintments. He had a weakened | | | | | | |
| | | nd needed any infection he may immediately. He informed | | | | | | |
| | have taken care of | miniculately. The informed | | | | | | |

| TAGREGULATORY OR LSC IDENTIFYING INFORMATIONnursing four times a day, upon receiving his medications, about his tooth pain, because they always brought him ice water with his medications, and he informed them he couldn't drink ice water due to the pain it caused his tooth. He had another appointment scheduled for $3/22/23$, but was uncertain whether it would happen either.An interview was conducted with SSA (Social Services Assistant) 2 on $3/14/23$ at 1:18 p.m. She indicated she was unsure what happened with his $3/2/23$ appointment, but that transportation did not show up for his December, 2022 and February, 2023 appointments. She stated, "We have a lot of issues with transportation," mostly due to staffing. They had a facility bus, but only one driver, who usually took residents to their regularly scheduled appointments, like dialysis. 2. The clinical record | 3114 EAST | DRESS, CITY, STATE, ZIP COD T 46TH STREET POLIS, IN 46205 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | E COMPLI |
|--|-----------|--|----------|
| PREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLP.TAGREGULATORY OR LSC IDENTIFYING INFORMATIONnursing four times a day, upon receiving his medications, about his tooth pain, because they always brought him ice water with his medications, and he informed them he couldn't drink ice water due to the pain it caused his tooth. He had another appointment scheduled for $3/22/23$, but was uncertain whether it would happen either.An interview was conducted with SSA (Social Services Assistant) 2 on $3/14/23$ at 1:18 p.m. She indicated she was unsure what happened with his $3/2/23$ appointment, but that transportation did not show up for his December, 2022 and February, 2023 appointments. She stated, "We have a lot of issues with transportation," mostly due to staffing. They had a facility bus, but only one driver, who usually took residents to their regularly scheduled appointments, like dialysis. 2. The clinical record | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR | COMPLI |
| nursing four times a day, upon receiving his medications, about his tooth pain, because they always brought him ice water with his medications, and he informed them he couldn't | TAG | DEFICIENCY) | DAT |
| for Resident D was reviewed on 3/14/23 at 11:30 a.m. The diagnoses for Resident D included, but were not limited to, hemiplegia. The resident's admission date was 11/28/20. A Quarterly Minimum Data Set (MDS) assessment, dated 2/4/23, indicated Resident D was cognitively intact. A social services progress note dated 10/12/22 indicated "Writer submitted online referral to [oral surgery facility]Writer to call to follow up on referral if office has not called by next week." A social services progress note dated 10/21/2022 indicated Resident D's dental appointment was scheduled for a consultation prior to extractions on 12/22/22 at 12:45 p.m. A social services progress note dated 12/22/22 | | | |

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155628 | (X2) MUI A. BUI B. WIN | LDING | nstruction 00 | CO | ate survey mpleted / 14/2023 |
|-------------------|-------------------------------------|---|------------------------------|-------------|---|----------------|---|
| | PROVIDER OR SUPPLIE | REHABILITATION CENTER | | 3114 EA | DDRESS, CITY, STATE, ZIF IST 46TH STREET APOLIS, IN 46205 | ? COD | |
| (X4) ID PREFIX | | Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | р | ID REFIX | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION | N SHOULD BE | (X5) COMPLETIC |
| TAG | | R LSC IDENTIFYING INFORMATION | - | TAG | CROSS-REFERENCED TO TH DEFICIENCY) | IE APPROPRIATE | DATE |
| into | | portation services that was | | into | | | DITL |
| | | acility to take Resident D to her | | | | | |
| | - | t did not show up to take her. | | | | | |
| | | appointment had been | | | | | |
| | | 15/23 at 10:30 a.m. | | | | | |
| | | s note dated 2/15/23 indicated | | | | | |
| | | issed her dental appointment | | | | | |
| | - | rgery facility indicated the | | | | | |
| | - | will not provide services to her, | | | | | |
| | | ot shown up to her scheduled | | | | | |
| | | would need to find another | | | | | |
| | oral surgeon for de | ental services. | | | | | |
| | | conducted with Resident D and 5 on $3/14/23$ at 11:48 a m | | | | | |
| | - | 5 on 3/14/23 at 11:48 a.m. | | | | | |
| | | ted transportation was arranged ne facility for outside | | | | | |
| | | e transportation service the | | | | | |
| | | of times does not show up to | | | | | |
| | - | side appointments or staff don't | | | | | |
| | | ere and they leave without her. | | | | | |
| | | o, she had a scheduled dental | | | | | |
| | - | the staff had not notified her the | | | | | |
| | | vice had arrived to pick her up. | | | | | |
| | - | id trouble reaching staff when | | | | | |
| | - | the unit to notify the staff the | | | | | |
| | | vice had arrived to take the her. | | | | | |
| | - | old the unit phone was on | | | | | |
| | | rtation service had left by the | | | | | |
| | - | ound out they were here to take | | | | | |
| | | d another scheduled dental | | | | | |
| | | ily Member 15 indicated the oral | | | | | |
| | | ; because Resident D had | | | | | |
| | | neduled appointments and | | | | | |
| | | ule any future appointments. | | | | | |
| | | over again and look for another | | | | | |
| | | t Resident D's tooth extraction. | | | | | |
| | | ot refuse to go to her | | | | | |
| | | nsportation has always been | | | | | |
| | | • | | | | | 1 |

PRINTED: 04/19/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/14/2023 155628 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3114 EAST 46TH STREET CREEKSIDE HEALTH AND REHABILITATION CENTER INDIANAPOLIS, IN 46205 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the problem. This problem with transportation has been on going for years for all outside appointments. An interview was conducted with Receptionist 10 on 3/14/23 at 12:23 p.m. She indicated about a month ago Resident D had a dental appointment, and she did miss the appointment. The transportation service had arrived and Receptionist 10 had called back on the unit by phone, but staff would not pick up to notify the resident she needed to come up to the front to go to her appointment. She had tried to notify the unit utilizing the overhead system, group text, and calling back to unit by phone and was unable to reach the nursing staff. Receptionist 10 walked back to the unit to notify the staff, but by the time she returned to the lobby the transportation service had left. The volume had been turned down on the unit's phone, so staff could not hear the phone ringing. The transportation service will only wait 15 minutes for the resident, and then they leave. Resident D had come to the lobby shortly after and was very upset that she had missed her dental appointment. An interview was conducted with the Executive Director 1 on 3/14/23 at 2:02 p.m. The facility uses a transportation service or the facility bus for residents that have outside appointments. Resident D had missed a dental appointment about a month ago. The resident was unable to use the bus for outside appointments due to her size, and the motorized wheelchair weight. She has to use the transportation service, but the service does not always show up to take her. The resident's dental appointment was rescheduled. The dental policy was provided by the Executive Director on 3/14/23 at 12:50 p.m. It indicated Event ID: VPRQ11 Facility ID: 009569 Page 15 of 16 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

04/19/2023 PRINTED: FORM APPROVED

PRINTED: 04/19/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| ENTERS FO | R MEDICARE & MEDIC | AID SERVICES | | | | OM | IB NO. 0938-039 |
|--------------------------|--|---|-----|---------------------|--|-----------------------------|----------------------------|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155628 | ì í | JILDING | nstruction <u>00</u> | (X3) DATE COMPI 03/14 | |
| | PROVIDER OR SUPPLIEF | REHABILITATION CENTER | - | 3114 E/ | ADDRESS, CITY, STATE, ZIP COD AST 46TH STREET APOLIS, IN 46205 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY) | E | (X5) COMPLETION DATE |
| | assure all resident's podiatry needs are s these areas11. Th in arranging for tran ancillary service pro | Hearing, Podiatry is the policy of this facility to with dental, vision, hearing, or seen by the Consultants in e facility will assist a resident asportation to and from outside oviders as recommended" | | | | | |

VPRQ11 Facility ID: 009569