STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING _____ B. WING _____	09/16/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely notify a resident's representative that the resident was placed in droplet isolation and a COVID 19 test would be obtained due to exposure of COVID 19 for 1 of 3 residents reviewed for infection control. (Resident F) Findings include: The clinical record was reviewed on 9/15/20 at 1:33 p.m. The [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A lab report, dated 5/30/20, indicated a specimen was collected from the resident for COVID 19, and lab reported the results on 5/30/20. An interview was conducted with the Assistant Director of Nursing (ADNS) on 9/16/20 at 9:03 a.m. She indicated she could not locate any documentation that the resident's representative was notified that Resident F had been exposed to COVID 19, placed in droplet precautions, or that a test was obtained with results. During a confidential interview on 9/16/20 at 9:59 a.m., they indicated Resident F's representative was not notified that the resident had been exposed to COVID 19. Resident F's representative had called the facility and requested to speak with the resident. She was denied the request, because Resident F was in droplet precautions. The staff reported the resident had been exposed to COVID 19 and tested days prior. At the time of the representative's call, the resident was at the end of her 14 day quarantine time. A Physician/Clinician/Family/Responsible Party Notification for Change in Condition policy was provided by the Director of Nursing (DON) on 9/16/20 at 12:37 p.m. It indicated Purpose: To ensure that medical/psychological care problems are communicated to the attending physician/clinician and family/representative in a timely, efficient and effective manner .Policy: 1. The facility must immediately inform the resident; consult with the resident's physician/clinician; and notify, consistent with his or her authority, the resident representative(s) when there is: A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); .2. When making notification as listed above, the facility must ensure that all pertinent information is documented in the resident's medical record .5. Even when a resident is mentally competent, his or her designated resident representative or family, as appropriate should be notified of significant changes in residents health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident . This Federal tag relates to compliant IN 828. 3.1-5(a)(3)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of abuse to the Indiana State Department of Health timely for 1 of 3 residents reviewed for abuse. (Resident J) Findings include: The clinical record of Resident J was reviewed on 9/14/20 at 2:40 p.m. The Resident's [DIAGNOSES REDACTED]. A Quarterly MDS (Minimum Data Set) Assessment, completed 6/11/2020, indicated she was cognitively intact. On 9/14/2020 at 11:15 a.m., the ED (Executive Director) provided the investigation file for an allegation of verbal abuse against Resident J. The incident report indicated the identified date and time of the incident was 7/29/2020 at 10:15 a.m., with a brief description of the Resident alleging that a staff member had cursed at her at about 9:15 p.m. on 7/28/2020. The investigation file contained a copy of an email, confirming submission of the incident to the Indiana State Department of Health. The date and time on the email confirmed submission on 7/30/2020 at 7:09 p.m. During an interview on 9/15/2020 at 1:45 p.m., the DON (Director of Nursing) indicated that the facility staff had reported the incident to her in a timely manner, however, she had not sent it to the Indiana State Department of Health within the 2 hour time frame. She had submitted it on 7/30/2020 at 7:09 a.m. On 9/14/2020 at 3:27 p.m., the DON provided the Abuse, Neglect and Misappropriation of Resident Property which read .Policy: This facility's policy is the resident has the right to be free of verbal, sexual, physical and mental abuse .Policy Interpretation and Implementation 7. The facility will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator of the facility and to other officials in accordance with the federal/state law through established procedures . (i) Report all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident proper immediately but not later than 2 hours . This Federal tag relates to complaint IN 731. 3.1-28(c)
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document thorough investigations for allegations of abuse for 1 of 3 residents investigated for abuse (Resident J) Finding include: The clinical record of Resident J was reviewed on 9/14/20 at 2:40 p.m. The Resident's [DIAGNOSES REDACTED]. A Quarterly MDS (Minimum Data Set) Assessment, completed 6/11/2020, indicated she was cognitively intact. On 9/14/2020 at 11:15 a.m., the ED (Executive Director) provided the investigation file for an allegation of verbal abuse against Resident J. The incident report indicated the identified date and time of the incident was 7/29/2020 at 10:15 a.m., with a brief description of the Resident alleging that a nurse had cursed at her at about 9:15 p.m. on 7/28/2020. The investigation included a statement from Resident J dated 7/29/2020. The statement indicated that Resident J had been interviewed about the nurse cursing at her. The investigation included interviews with 3 other residents who had been cared for by the staff member on 7/28/2020. The investigation file did not include an interview with the nurse or interviews with any other staff members who had worked at the time of the alleged incident. During an interview on 9/16/2020 at 11:50 a.m., the DON (Director of Nursing) indicated she had interviewed the nurse and the 2 CNA's (Certified Nursing Assistants) who had worked on the unit that evening. She has not included the interviews in the investigation file. She had not interviewed any other staff members working that evening. During an interview on 9/16/2020 at 12:15 p.m., the RDO (Regional Director of Operations) indicated he would expect the investigation file to include interviews with the alleged perpetrator and other staff members to be included in the investigation file. On 9/14/2020 at 3:27 p.m., the DON provided the Abuse, Neglect and Misappropriation of Resident Property which read .Policy: This facility's policy is the resident has the right to be free of verbal, sexual, physical and mental abuse .Policy Interpretation and Implementation .10. The facility will keep evidence that all alleged violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress . This Federal tag relates to complaint IN 731. 3.1-28(d)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation and interview, the facility failed to ensure infection control practices were followed during the

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) COVID-19 pandemic for residents related to a staff member properly wearing a face mask, hand hygiene, and not maintaining a 6 foot distance between family members and residents during outdoor visitation for 5 of 5 Infection Prevention observations. (ACT 1, CNA 1, PCA 2, and outside visitation area) Findings include: 1. An observation was made on 9/15/20 at 11:09 a.m., of ACT 1 (activities staff). ACT 1 was walking outside to the outdoor visitation area and had her mask down below her nose thus leaving her nose uncovered. An observation was made on 9/15/20 at 11:34 a.m., of ACT 1. ACT 1 was walking in the hallway near the DON's (Director of Nursing) office and had her mask down below her nose thus leaving her nose uncovered. A Mask Conservation Process policy received on 9/14/20 from the ADN (Assistant Director of Nursing) indicated, The mask must be worn at all times, while in the facility, even when you are in an area by yourself such as an office. The mask can be removed to eat and drink during your break time in the facility designated area while continuing to maintain good hand hygiene and social distancing requirements . 2. An observation was made on 9/15/20 at 9:10 a.m., of CNA (Certified Nursing Assistant) 1. CNA 1 was delivering breakfast trays to the residents on the 100 hallway. CNA 1 had a cart with several residents breakfast trays on it. CNA 1 grabbed the breakfast tray for Resident W from the cart and entered Resident W's room. CNA 1 set the tray on the resident's bed side table then opened the food containers and plastic silverware for the resident. She then adjusted the bed side table so it was in reach for Resident W. CNA 1 did not perform hand hygiene prior to entering Resident W's room, did not don gloves prior to touching the resident's bedside table, nor did she perform hand hygiene after exiting Resident W's room. Resident W was not offered or encouraged to perform hand hygiene prior to eating. After exiting Resident W's room, CNA 1 then went back to the cart of meal trays and picked up Resident F's breakfast tray. CNA 1 entered into Resident F's room with the meal tray, set it down on the bedside table, opened the containers and the plastic silverware for Resident F. CNA 1 then adjusted the bedside table for Resident F and exited the room. CNA 1 did not perform hand hygiene prior to entering Resident F's room, did not don gloves prior to touching the bedside table, nor did she perform hand hygiene after exiting Resident F's room. Resident F was not offered nor encouraged to perform hand hygiene prior to eating. An interview with CNA 1 immediately followed the observation on 9/15/20. CNA 1 indicated, hand hygiene needed to be done prior to entering a resident's room and after exiting the resident's room. A Hand Washing policy provided by ADN on 9/16/20, indicated, When you may use Alcohol Based Hand Rub: .Before direct patient contact .After direct patent contact,,,After contact with inanimate objects in the residents'/patients' immediate environment . 3. An observation was made on 9/15/20 at 9:19 a.m., of PCA (Patient Care Assistant) 2. PCA 2 was delivering breakfast trays on the 200 hallway. PCA 2 performed hand hygiene prior to entering into Resident G's room with her breakfast tray. PCA 2 offered and opened containers and plastic silverware for the resident. PCA 2 exited the room and performed hand hygiene. PCA 2 did not offer or encourage Resident G to perform hand hygiene prior to eating. 4. An observation was made on 9/15/20 at 11:17 a.m., of the facility's outside visitation area. A resident was sitting in her wheelchair pulled up to a small card table that appeared to be approximately 4 ft by 2 ft. The resident was seated at the long end of the table. One of the visitors was seated at the opposite long end of the table while another visitor was on the right side of the table near the first visitor. The visitors and resident did not appear to be at least 6 feet apart. An interview with DON (Director of Nursing) on 9/15/20 at 11:17 a.m., was conducted during the observation. DON indicated, the facility has marked the minimum 6 foot distance on the pavement using a blue taped X mark. She concluded the visitors and the resident were not seated at least 6 feet apart since the visitors, the table, and the resident were all within the two blue X marks indicating they were all less than 6 feet from each other. DON further stated the tables were to be used as a barrier and not meant to be pulled up to for the visit. This Federal Tag relates to complaints IN 928, IN 484, IN 828, IN 996, and IN 197. 3.1-18