STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESIDENCES AT COFFEE CREEK	2300 VILLAGE POINT CHESTERTON, IN 46304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: 2/26/25 and 2/27/25 Facility number: 014469 Residential Census: 101 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/3/25.	R 0000	Residences at Coffee Creek (the "Provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider herby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the state of Indiana or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on	

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

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

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			that basis. We are requesting paper compliance for the deficiencies cited.	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on record review and interview, the facility failed to notify the physician of a blood sugar level outside of the ordered parameters for 1 of 1 resident reviewed for insulin administration. (Resident 7) Finding includes: The record for Resident 7 was reviewed on 2/26/25 at 3:14 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, long term insulin use, and hypertension. A Physician's Order, dated 2/12/24 and listed on the current Physician Order Summary, indicated Humalog Insulin was to be administered on a sliding scale (insulin dosage based on blood sugar levels) three times a day as follows: 151-200 = 3 units 201- 250 = 5 units 251-300 = 7 units 301-350 = 9 units 351-and up = 11 units/ Call MD. The February 2024 Medication Administration Record (MAR) indicated the resident had a blood sugar level of 369 on 2/4/25 and a blood sugar level of 450 on 2/25/25. There was no documentation that indicated nursing staff reported the blood sugar levels outside of the parameters to the physician as	R 0036	Resident 7 did not experience any negative outcomes associated with this finding. Resident 7's physician has been notified of this blood sugar level that was outside parameters. An in-service was completed for all nurses on following physician orders and notifying a physician when blood sugar levels are out of parameters. An audit will be completed by the Director of Resident Services or designee of all residents that currently receive blood glucose monitoring for 60 days or until 100% compliance is achieved to ensure the physicians are notified of any blood sugar levels outside of parameters. These audits will be reviewed at the quality assurance committee. These systematic changes will be put into place by March 29, 2025.	03/29/2025

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	ordered. During an interview on 2/27/25 at 10:48 a.m., LPN 1 indicated that nursing staff did not contact the doctor as ordered when the resident's blood sugar level went above 351. During an interview on 2/27/25 at 10:59 a.m., the Director of Nursing indicated there was no documentation verifying the nursing staff contacted the doctor when the resident's blood sugar levels were outside of the parameters.			
R 0044 Bldg. 00	410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to lack of discharge documentation and instructions for continuity of care for 1 of 2 residents reviewed for closed records. (Resident 9) Finding includes: The closed record for Resident 9 was reviewed on 2/26/25 at 3:10 p.m. Diagnoses included, but were not limited to dementia. A Nurse's Note, dated 12/19/24 at 7:28 a.m., indicated the resident left the facility with family. There were no discharge instructions prepared and in writing regarding the resident's medications, follow up appointments (if any), or any other type of information for continuity of care. During an interview on 2/27/25 at 10:00 a.m., the Administrator indicated they have never prepared	R 0044		

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	discharge instructions for a resident and was unaware they needed to do so, as they do not have many residents leave and go back home.			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance Based on record review and interview, the facility failed to ensure at least twelve fire drills were conducted each year, that they were conducted quarterly on each shift, and that the local fire department was invited to participate at least every six months. This had the potential to affect all 101 residents who resided in the facility. Finding includes: The facility's Fire Drill Reports were reviewed on 2/26/25 at 11:15 a.m. Reports were received of drills conducted on the following days/shifts: 2/1/24 at 10:00 a.m. (first shift), 3/20/24 at 5:45 a.m. (first shift), 4/11/24 at 5:35 p.m. (second shift), 5/23/24 at 5:15 a.m. (third shift), 6/14/24 at 8:00 a.m. (first shift), 8/5/24 at 2:14 p.m. (second shift), 9/19/24 at 6:35 a.m. (first shift), 11/26/24 at 7:30 a.m. (first shift), 12/5/24 at 730 a.m. (first shift) and 1/5/25 at 7:32 a.m. (first shift). There was no documentation of the local fire department being invited or participating in the reports reviewed. During an interview on 2/26/25 at 2:13 p.m., the Administrator indicated she had no other fire drill reports, she knew some were missing, and she had no documentation of the local fire department being invited to participate in any fire drills.	R 0092	No residents experienced negative outcomes associated with this finding. A fire drill was not conducted in July 2024 and October 2024. A new director has taken over in November and all fire drills were completed accurately and completely. The Director of Plant Operations or designee will ensure a fire drill is conducted on each shift at least quarterly. The fire drill will be scheduled in advance and documented accordingly. Also, the Director of Plant Operations or designee will schedule a fire drill with the local fire department as least every 6 months. The local fire department was contacted on 3/10/25 and 3/14/25 regarding scheduling a fire drill at the community. We are currently waiting on a date. The fire drill documentation will be routinely reviewed at the quality assurance committee. These systematic changes will be put into place by March 29, 2015.	03/29/2025
R 0118	410 IAC 16.2-5-1.4(c) Personnel - Deficiency			

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Bldg. 00	Based on record review and interview, the facility failed to ensure all unlicensed employees providing more than limited assistance to residents had an active certified nurse's aide (CNA) certificate for 1 of 41 CNA files reviewed. (CNA 4) Finding includes: The employee file for CNA 4 was reviewed on 2/27/28 at 12:20 p.m. There was no documentation of an active CNA certification. A 2/27/25 search on the Indiana Professional Licensing Agency website indicated CNA 4's certification expired on 1/2/25. During an interview on 2/27/28 at 12:25 p.m., the Human Resources Director indicated CNA 4 had been working that day, but they sent her home when they found she had not renewed her certification.	R 0118	No residents experienced negative outcomes associated with this finding. Upon discovering the CNA has an expired license, she was sent home immediately and suspended until her license was renewed. The Human Resources Director or designee will log all licenses and expiration dates when a new employee starts orientation in our payroll system. A license report will be pulled monthly to ensure all licenses are active. These reports will be routinely reviewed at the quality assurance committee. These systematic changes will be put into place by 2/28/25.	02/28/2025
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure annual inservices were held related to infection control for 2 of 5 employee files reviewed. (QMA 1 and RN 1) Finding includes: Review of the employee files on 2/27/25 at 11:30 a.m. indicated the following: a. The employee file for QMA 1, who was hired on 10/30/20, lacked documentation the employee had received an annual infection control inservice	R 0120	An in-service was completed for all nursing staff on infection control. The Director Human Resources or designee will track all in-services that are completed for the nursing staff to ensure that all in-services are complete according to state guidelines for infection control. The Director of Human resources or designee will audit these in-services monthly to ensure that staff have been in-serviced on infection control at least annually.	03/29/2025

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	for 2024. b. The employee file for RN 1, who was hired on 8/22/20, lacked documentation the employee had received an annual infection control inservice for 2024. c. A folder which contained the 2024 inservices that were provided to staff indicated there was no inservice related to infection control. During an interview on 2/27/25 at 10:50 a.m., the Director of Resident Services indicated staff were educated about infection control "as it came up." There was no scheduled training and/or inservices.		These audits will be reviewed routinely at the quality assurance committee as our ongoing compliance. These systematic changes will be in place March 29, 2025	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on observation, record review, and interview, the facility failed to ensure service plans were signed by the resident or family member and accurate and reflective of the resident's current status related to open wounds, weight, diet, and assistance with eating for 3 of 8 sampled residents. (Residents 3, 4, and 6) Findings include: 1. During an observation on 2/26/25 at 12:20 p.m., Resident 3 was observed in a broda chair in the memory care dining room. She was served lunch, which consisted of pureed food and nectar thick liquids. At that time, CNA 1 sat down and spoon fed her, as the resident could not feed herself. The record for Resident 3 was reviewed on 2/26/25 at 11:00 a.m., Diagnoses included, but were not limited to, dementia.	R 0217	No other residents experienced negative outcomes associated with this finding. Resident #3, #4, and #6 did not experience any negative outcomes associated with this finding. The Service plans for residents #3, #4, and #6 will be reviewed, updated, and signed by the POA and/or resident. Nursing staff will complete an in-service on this finding. Director of resident Services or designee will review all resident charts to ensure that service plans are updated, reviewed, and signed and no other residents were affected by this finding. As part of the admission process or a significant change in condition, the	03/29/2025

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	The current 1/31/25 Service Plan indicated the resident had no open areas, was on a regular diet and only required set up or cues for eating. The plan also did not address the resident's current weight loss. A Physician's Order, dated 2/7/25, indicated pureed diet with nectar thick liquids. Physician's Orders, dated 2/17/25, indicated to cleanse the open area to the coccyx with wound wash, pat dry, and apply sure prep to the periwound. Cleanse the skin tear to the left back with wound wash, pat dry, apply Xerofoam gauze and cover with a foam dressing. Cleanse the deep tissue injury to the right hip with wound wash, pat dry, and cover with a foam dressing. Cleanse the blister to the right shin with wound wash, pat dry, cover with a four by four and wrap with kerlix for protection. The Hospice RN would change all bandages three times a week and staff was to change if soiled or dislodged. A Registered Dietitian (RD) note, dated 2/24/25, indicated the resident's weight was 69 pounds, which was down 10.2 pounds in the last month for a 12.9% weight loss. The resident may benefit from pudding at lunch and supper, smooth yogurt at all meals and Ensure or Boost twice a day. During an interview on 2/26/25 at 2:45 p.m., the Director of Residential Services indicated the resident's decline had been in the last month, but she was aware that her service plan needed to be updated again.2. The record for Resident 4 was reviewed on 2/26/25 at 10:30 a.m. Diagnoses included, but were not limited to, neurocognitive disorder and depression.		Director of Resident Services or designee will ensure that the resident service plan is complete, reviewed, and signed by the resident or their representative.Director of Resident Services or designee will audit all new resident charts within 48 hours of admission and as needed until 100% compliance is achieved to ensure ongoing compliance with this requirement. These audits will be reviewed routinely at the quality assurance committee.These systematic changes will be in place March 29, 2025	

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	A Service Plan, dated 1/31/25, indicated the resident had mild to moderate cognitive impairment and needed guidance 1-3 times a day. The resident was dependent for transfers, requiring a Hoyer (mechanical transfer device) lift, and required hands-on assistance with bathing/dressing. The Service Plan was not signed by the responsible party. During an interview on 2/27/25 at 10:50 a.m., the Director of Residential Services indicated she did not have a signed service plan for the resident, and it was something she was working on. 3. The record for Resident 6 was reviewed on 2/26/25 at 3:43 p.m. Diagnoses included, but were not limited to, urinary retention and Parkinson's Disease. A Service Plan, dated 2/3/25, indicated the resident was cognitively intact for daily decision making, required supervision with transfers and was independent with bathing/dressing. The Service Plan was not signed by the responsible party. During an interview on 2/27/25 at 10:50 a.m., the Director of Residential Services indicated she did not have a signed service plan for the resident, and it was something she was working on.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review, and	R 0273	No residents experienced negative	03/29/2025

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	interview, the facility failed to ensure food was prepared under sanitary conditions related to staff touching food with gloved hands and staff serving food without hair restraints for 1 of 1 kitchen area and for 1 of 1 meal observed. (The Main Kitchen and the Lunch Meal) This had the potential to affect all 103 residents in the facility receiving food from the kitchen. Findings include: 1. During the kitchen sanitation tour, on 2/26/25 at 10:47 a.m., Cook 1 was observed preparing a chicken wrap. The Cook was wearing a pair of disposable gloves and he was observed placing diced tomatoes with his gloved hands on a flour tortilla. The Cook then proceeded to open a cabinet door with the same gloved hands and he obtained a knife and a chicken breast. He touched the chicken breast with the same gloved hands after opening the cabinet door and touching the knife handle. During an interview at that time, the Executive Chef indicated the Cook should have changed his gloves in between touching the cabinet door and all of the other items. The undated facility policy, titled "Handwashing and Glove Usage in Food Service" was provided by the Executive Chef on 2/27/25 at 10:00 a.m. and identified as current. The policy indicated gloves should be changed as soon as they become dirty or torn, before beginning a different task, and after handling raw meat, seafood or poultry and before handling ready to eat food. 2. During the lunch meal observation on 2/26/25 in the memory care dining room, the food was brought to the unit in closed carts by dietary staff at 11:52 a.m. The dietary staff placed the food containers on the		outcomes associated with this finding. 1. An in-service was completed by the Executive Chef for the Dining services staff on glove wearing. All new dining service employees are trained on how to properly wear gloves as a part of their orientation. The Executive Chef or designee will randomly audit and observe the dining services staff to ensure they are properly wearing gloves until 100% compliance is achieved. These audits will be reviewed routinely at the quality assurance committee as our ongoing compliance. These systematic changes will be in place by March 29, 2025. No residents experienced negative outcomes associated with this finding. 2. An in-service was completed by the Director of Resident Services for the nursing staff on serving food in compliance with sanitary standards. All new resident services employees will be trained on wearing hairnets. The Director of Resident Services or designee will randomly audit and observe the resident services staff to ensure they are serving food in compliance with sanitary standards until 100% compliance is achieved. These audits will be reviewed routinely at the quality assurance	

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	counter and inside the heated dish. They brought a pan of red velvet cake, a container of soup, and a half pan of uncut cornbread. The dietary staff then left the unit. At that time, CNA 1 placed clean utensils in the food and started to serve the food on the plates. She was not wearing a hair restraint. At 12:06 p.m. CNA 3 was observed pouring soup into bowls to serve the residents. At that time she was not wearing a hair restraint. At 12:36 p.m., CNA 2 was observed scooping out the red velvet cake into serving bowls. She was not wearing a hair restraint. During an interview on 2/26/25 at 12:25 p.m., CNA 1 indicated she was unaware she had to wear a hair net when serving the residents' food during meals. During an interview 2/26/25 at 12:30 p.m., CNA 3 indicated she was not informed about wearing a hair net when she served the food. During an interview with on 2/27/25 at 8:45 a.m., the Director of Residential Services indicated she was unaware nursing staff needed to wear hair nets when serving the food.		committee as our ongoing compliance. These systematic changes will be in place by 2/28/25. After review of the Retail Food Establishment and Sanitation Requirements Title 410 IAC 7-24 effective November 13, 2004, it was noted that page 30 section 410 IAC 7-24-138 titled "Effectiveness of hair restraint" Sec. 138. (b) this section does not apply to food employees, such as counter staff who only serve beverages and wrapped packages food, hostesses, and wait staff, if they present minimal risk of contaminating: (1) exposed food; (2) clean equipment, utensils, and linens; and (3) unwrapped single-service and single-use articles. All nursing staff are wait staff and will be reminded to wear their hair pulled back if the risk of contaminating the food they are serving is more than a minimal risk of contaminating the served food. During the survey, staff posed a minimal risk to contaminating food that they were functioning as wait staff at the time of serving. The staff were not preparing food.	
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance Based on observation, record review, and	R 0274	No residents experienced negative	03/07/2025

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	interview, the facility failed to ensure the recipe was followed by food service staff related to pureed food preparation. This had the potential to affect the five residents who received a pureed diet. The facility also failed to ensure thickened liquids were prepared based on manufacturer recommendations and residents who received a pureed diet were offered soup for 1 of 3 residents who received a pureed diet on the Memory Care Unit. (Resident 3) Findings include: 1. On 2/26/25 at 10:57 a.m., Sous Chef 1 was observed preparing pureed smothered porches. The Sous Chef placed 2 porches along with the sauce inside of the blender. While blending, the Sous Chef added water to the mixture from a plastic container. When asked how much water was added, the Sous Chef indicated, "about four tablespoons." The Sous Chef did not use a measuring spoon when adding the water. The recipe for the smothered pork chops was provided by the Executive Chef on 2/27/25 at 10:00 a.m. The recipe indicated each serving was to be processed with the sauce and gradually add 2-4 tablespoons of chicken stock until smooth, adding more if necessary. During an interview on 2/27/25 at 10:22 a.m., the Executive Chef indicated chicken stock should have been used instead of the water and a measuring spoon or cup should have been used as well. She also indicated she would inservice the staff. 2. During the lunch meal observation on 2/26/25 on the memory care dining room, the food was brought to the unit in closed carts by dietary staff at 11:52 a.m. The dietary staff placed the food containers on the counter and the heated dish.		outcomes associated with this finding. 1. An in-service was completed by the Executive Chef for the Dining services staff on how to properly puree meals. Recipes from our menu program were be provided for pureed meals and given to the trained dining services staff when the weekly menu is made. All new dining service employees will be trained on how to properly puree food. This training will be added to their skills/orientation checklist. The Executive Chef or designee will randomly audit and observe the dining services staff when making purees. 2. The dining services staff will be preparing all thickened liquids for the residents. An in-service was completed by the Executive Chef for the Dining services staff on how to properly thicken liquids if not using pre-thickened. All new dining service employees will be trained on how to properly thicken liquids. This training will be added to their skills/orientation checklist. The Executive Chef or designee will randomly audit and observe the dining services staff when making thickened liquids. 3. An in-service was completed by the Executive Chef for the Dining services staff on providing pureed soups and desserts with meals. The Executive Chef or designee will randomly audit meal	

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RESIDENCES AT COFFEE CREEK	2300 VILLAGE POINT CHESTERTON, IN 46304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	They brought a pan of red velvet care, a container of soup, and a half pan of uncut cornbread. The dietary staff then left the unit. At that time, CNA 1 placed clean utensils in the food and started to serve the food on the plates. At 12:06 p.m. CNA 3 was observed pouring soup into bowls to serve the residents. There was no pureed soup prepared for those residents who were served a pureed meal. The staff did not cut or serve the cornbread to any of the residents. At 12:18 p.m., the dietary staff brought Resident 3 her food, which consisted of pureed meat, a vegetable, and mashed potatoes. At 12:20 p.m., CNA 1 removed the lid from the white 16 ounce Styrofoam cup filled with apple juice and added two teaspoons of instant food thickener and stirred the mixture. She put the lid back on the cup and sat down to feed the resident. During an interview on 2/26/25 at 12:25 p.m., CNA 1 indicated she normally put two or three teaspoons of the thickener in the cup and stirred. The label on the instant food thickener indicated, for a four ounce serving, add one tablespoon of thickener for mildly thick nectar consistency. At 12:36 p.m., CNA 2 was observed scooping out the red velvet cake into serving bowls. There was no pureed cake or another dessert for those residents who received a pureed meal. During an interview on 2/27/25 at 8:45 a.m., the		times to ensure pureed soup and desserts are offered. In addition, the nursing staff will be educated on serving all items on the menu to the residents. These audits will be reviewed routinely at the quality assurance committee.These systematic changes will be put into place on March 7, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/27/2025

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	Director of Residential Services indicated the CNAs should have followed the directions on the back of the thickener can, as they do not have pre-thickened liquids.			