

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2026
NAME OF PROVIDER OR SUPPLIER Creekside Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E Douglas Rd Mishawaka, IN 46545	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to ensure a medication was administered as ordered by the physician for 1 of 3 residents reviewed for medication administration, (Resident B). Finding includes: Resident B's clinical record was reviewed on 7/13/26 at 10:04 A.M. Diagnoses included but were not limited to senile degeneration of brain, chronic respiratory failure with hypoxia, chronic kidney disease, cerebral cysts, and anxiety. Resident B was under the care of hospice services. Review of Resident B's physician orders included but were not limited to: Hydromorphone, take 1/2 of a 2 mg (1 mg) tablet by mouth two times daily between 7:00 A.M. and 11:00 A.M., and between 7:00 P.M. to 11:00 P.M., for Shortness of Breath or difficulty in breathing. The order start date was 6/13/26 at 7:09 P.M., and the order was discontinued on 6/15/26 at 9:21 A.M. Hydromorphone, to take 1/2 of a 2 mg tablet (1 mg) by mouth every 3 hours as needed every three hours, with a start date of 6/13/26 at 7:06 P.M. and discontinued on 6/15/26 at 9:21 A.M. Review of Resident B's Medication Administration Record (MAR), from 6/13/26 to 6/15/26 indicated the resident did not receive either the scheduled nor any as needed doses of Hydromorphone. Notations in the MAR indicated on 6/13/26 from 7:00 P.M. to 11:00 P.M., the medication was not administered because it was unavailable and on 6/14/26 from 7:00 A.M. to 11:00 A.M., the medication was not administered and was on hold. A Nursing Progress Note dated 6/13/26 at 7:10 P.M., indicated Resident B's hospice nurse and responsible party were with the resident and hospice had evaluated the resident and issued a new order for Hydromorphone [Hydromorphone] 2 mg half tablet two times daily and Hydromorphone [Hydromorphone] 2 mg [1/2 tablet] every three hours as needed for shortness of breath and difficulty breathing. A Hospice Visit Note Report dated 6/13/26 at 6:23 P.M., indicated, 'Upon arrival. He is hallucination. POA [Responsible Party]. we discussed options to add medication for comfort. he is experiencing some mild dyspnea evidenced by a slight noise and slight use of accessory muscles. Contacted [Director of Nursing and physician]. requested a 'small dose of Dilaudid [hydromorphone] to start.' Orders from [physician] for 1 mg BID [twice daily] and 1 mg Q3H PRN [every three hours as needed]. [facility nurse] contacted their pharmacy that does not have the liquid formulation in stock. Educated to combine with drops of warm water to dissolve and administer sublingual, verbalizes understanding. During an interview with the Director of Nursing (DON) on 7/13/26 at 12:09 P.M., she indicated when hospice was with the resident, on the evening of 6/14/26, they had discussed the addition of comfort medications for Resident B. The DON indicated she had advised hospice that the resident had had morphine before and had experienced a rash that appeared to be caused by the morphine, so hospice had prescribed a low dose of hydromorphone in liquid form. The DON indicated they had advised hospice that their pharmacy did not have the liquid formulation in stock, so the hospice nurse had indicated the facility nursing staff should give one half of a 2 gm tablet dose and dilute it in warm water and administer the liquid under the resident's tongue. The DON indicated she was later notified that the facility stock of (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hydromorphone 2mg could not be cut in half so nursing staff could not administer the medication. The DON indicated the medication had arrived from the pharmacy on 6/15/26 by noon, but the resident had transferred to another facility by that time. The DON indicated the nurse should have notified hospice and the physician that the medication as ordered was not available but had failed to do so. On 7/13/26 at 11:59 A.M., the Corporate Consultant provided a policy titled, Medication Shortages/Unavailable Medications dated 1/1/13 and indicated it was the current facility policy. The policy indicated, .Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. a licensed Facility nurse should obtain the ordered medication from the Emergency Medication Supply. If the ordered medication is not available in the Emergency Medication Supply, the Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. If an emergency deliver is unavailable, Facility nurse should contact the attending physician to obtain orders or directions. This Federal tag relates to Intake 3049189.410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)		