STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Village	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure staff accurately administered physician ordered medications and treatments for 2 of 2 residents reviewed for standards of care. (Residents 1 and 18)Finding includes:1. During an observation on 3/25/2025 at 2:22 P.M. Resident 1's oxygen concentrator was dirty and dusty. The filter on the back of the concentrator had a clump of dust clinging to it. A record review for Resident 1 was completed on 3/27/2026 at 8:40 A.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and emphysema. Physician Orders, initiated on 3/12/2024 for Resident 1 included, but were not limited to, change oxygen tubing, change humidity, clean oxygen concentrator, and clean filter once a day on Sundays. A Medication Administration Record for Resident 1, dated March 2026, showed the oxygen tubing and humidity, and the oxygen concentrator and filter were documented as having been cleaned as indicated by staff initials on: -3/1/2026 initialed as completed by QMA 3. -3/8/2026 initialed as completed by QMA 3. -3/15/2026 initialed as completed by LPN 4. -3/22/2026 initialed as completed by QMA 3. -3/29/2026 initialed as completed by LPN 2. During an observation and interview with the Unit Manager on 3/31/2026 at 9:52 A.M., she confirmed the oxygen concentrator and filter were dusty and dirty. The Unit Manger indicated the concentrator should have been cleaned on Sunday, 3/29/2026, and should have been cleaned weekly on Sundays. During an interview on 3/31/2026 at 3:00 P.M., the DON indicated staff should not have initialed tasks until after they had been completed. She indicated staff were oriented to this expected standard during orientation. Review of the following staff member's personnel records, on 3/31/2026 at 2:00 P.M. indicated the (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following employees had completed the Medication Administration orientation checklist: -LPN 2 on 3/20/2026. -LPN 4 on 3/11/2026. -QMA 3 on 2/28/2026. 2. The clinical record of Resident 18 was reviewed on 3/30/2026 at 10:33 A.M. The resident's diagnoses included, but were no limited to: Parkinson's disease, cellulitis of right lower limb, urinary tract infection, lymphedema, neuromuscular dysfunction of bladder, muscle weakness, hypertension, pemphigus foliaceous, presence of pacemaker and personal history of other venous thrombosis and embolism. A Significant change Minimum Data Set (MDS) assessment, dated 1/11/26, indicated Resident 18 was moderately cognitively impaired. A Weekly Skin Assessment, dated 3/18/2026 at 11:56 P.M., indicated Resident 18 had had lotion applied to his feet and had redness to his right lower abdominal quadrant and the areas under his umbilicus and scrotal area. Physician Orders included, but were not limited to: Eucerin Original (lanolin-mineral oil), initiated on 3/25/2026, lotion; was to be applied twice daily to dry skin and Hydrocortisone Ointment: 2.5 % strength, initiated on 3/25/2026, was to be applied to face, legs and lower abdomen (not the folds) for redness twice a day. A March Medication Administration Record (MAR) 2026 indicated the Hydrocortisone Ointment 2.5% strength was ordered on 3/25/2026 and was documented as having been administered starting on the day shift of 3/25/2026. The March 2026 MAR indicated Resident 18's Eucerin lotion had been documented as having been administered as ordered, staring on 3/25/2026, as well. During an interview, on 3/26/2026 at 1:58 P.M., Resident 18 indicated he was supposed to have two different specific creams for his umbilical region but the facility had not had administered them yet. The resident indicated he had an autoimmune disorder that caused problems with his skin, called pemphigus foliaceous. During an interview, on 3/30/2026 at 1:30 P.M., Resident 18 indicated he had not received any medicated creams or Eucerin lotion from nursing staff. He indicated he had asked several times but had never received either treatment. Resident 18 indicated the nursing staff had been applying the facility brand lotion to his legs. Resident 18 indicated the nursing staff were supposed to be using Eucerin brand lotion because of the recommendation of his dermatologist. During an interview, on 3/30/2026 at 2:48 P.M., Employee 7 indicated the physician's order for the ointments and Eucerin lotion had been changed, on 3/25/2026, from an as needed basis to a scheduled medication/treatment. She indicated the tubes of ointment and bottle of Eucerin lotion were being used for the resident and if there were not any opened tubes or opened bottles, the facility must have already emptied them and thrown them away. During an observation, on 3/30/2026 at 2:50 P.M., with Employee 8, three unopened tubes of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hydrocortisone ointment with Resident 18's name on them, all without any open dates were located in the 200 hall's treatment cart and none were located in the unit's medication cart. These hydrocortisone ointments had the following pharmacy dispense dates: 9/12/2025, 2/4/2026 and 3/25/2026. The Eucerin lotion for Resident 18 had an open date of 3/27/2026. During an interview, on 3/31/2026 at 1:23 P.M., Resident 18 indicated he had been receiving the Eucerin lotion since yesterday and was going to have his hydrocortisone cream applied after lunch. The resident indicated the abdominal area of skin had not been itching or burning him. Resident 18 indicated he has had some itching on his legs bilaterally because of his lymphedema. During an interview and observation, Resident 18's skin was completed with Employee 9 on 3/31/2026 at 2:13 P.M. Resident 18 had reddened and excoriated skin to the entire lower half of his abdomen. The resident denied pain, discomfort or itching to skin area. There were no other areas of skin redness or excoriation visible. On 3/31/2026 at 2:30 P.M., the Executive Director indicated the facility did not have a policy for following physician orders nor a policy for accurate records. 3.1 -35(g)(1)

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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 observation, interview and record review, the facility failed to ensure treatments to address a skin condition were administered for 1 of 1 reisdents reviewed for skin conditions. (Resident 18)Findings included:The clinical record of Resident 18 was reviewed on 3/30/2026 at 10:33 A.M. The resident's diagnoses included, but were no limited to: Parkinson's disease, cellulitis of right lower limb, urinary tract infection, lymphedema, neuromuscular dysfunction of bladder, muscle weakness, hypertension, pemphigus foliaceous, presence of pacemaker and personal history of other venous thrombosis and embolism. A Significant Change Minimum Data Set (MDS) assessment, dated 1/11/26, indicated Resident 18 was moderately cognitively impaired. Physician Orders included, but were not limited to: Eucerin Original (lanolin-mineral oil), dated 3/25/2026, lotion; was to be applied twice daily to dry skin and Hydrocortisone Ointment: 2.5 % strength, dated 3/25/2026, was to be applied to face, legs and lower abdomen (not the folds) for redness twice a day.A March Medication Administration Record (MAR) 2026 indicated the Hydrocortisone Ointment 2.5% strength was ordered on 3/25/2026 and administered starting on the day shift of 3/25/2026. The March 2026 MAR indicated Resident 18's Eucerin lotion started to be administered on 3/25/2026, as well.During an interview, on 3/26/2026 at 1:58 P.M., Resident 18 indicated he should have had two different creams for his umbilical region but has not had them administered. The resident indicated he had an autoimmune disorder that caused problems with his skin, called pemphigus foliaceous.During an interview, on 3/30/2026 at 1:30 P.M., Resident 18 indicated he had not received any medicated creams or Eucerin lotion from nursing staff. He indicated he had asked several times but had never received either treatment. Resident 18 indicated the nursing staff had been applying the facility brand lotion to his legs. Resident 18 indicated the nursing staff were supposed to be using Eucerin brand lotion because of the recommendation of his dermatologist.During an interview, on 3/30/2026 at 2:48 P.M., Employee 7 indicated the order for the Hydrocortisone cream and Eucerin lotion had changed on 3/25/2026, and both treatments were ordered as scheduled instead of as needed. She indicated the nursing staff were using the designated lotion and ointment. During an observation and interview, on 3/30/2026 at 2:50 P.M. with Employee 8, three unopened tubes of hydrocortisone ointment with Resident 18's name, all without any open dates were noted in the medication room. The hydrocortisone ointments had the following pharmacy dispense dates: 9/12/2025, 2/4/2026 and 3/25/2026. The Eucerin lotion bottle was opened for this resident had an opened date of 3/27/2026. Thus, although Employee 7 indicated the ordered treatments had been applied, there was no explanation as to why none of the ordered hydrocortisone tubes had been opened and the Eucerin lotion had an opened date of 3/27/2026 even though the lotion had been documented as having been applied prior to 3/27/2026.During an interview, on 3/31/2026 at 1:23 P.M., Resident 18 indicated he had been receiving the Eucerin lotion since yesterday and was going to have his hydrocortisone cream applied after lunch. During an interview and observation, on 3/31/2026 at 2:13 P.M., a skin observation of Resident 18's skin was completed with Employee 9. Resident 18 had reddened and excoriated skin to the entire lower half of his abdomen. Resident denied pain, discomfort or itching to skin area. There were no other areas of skin redness or excoriation visible.On 3/31/2026 at 2:30 P.M., the Executive Director indicated the facility did not have a policy for following physician orders nor a policy for accurate records.410 IAC 3.1 - 37

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide oxygen according to the standards of practice regarding changing oxygen tubing and cleaning the oxygen concentrator and filter for 2 of 2 residents reviewed for respiratory care. (Residents 1 and 61)Findings include: 1. During an observation on [DATE] at 2:22 P.M. Resident 1's oxygen concentrator was found to be dirty and dusty. The filter on the back of the concentrator had a clump of dust clinging to it. A record review for Resident 1 was completed on [DATE] at 8:40 A.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and emphysema. Physician Orders, initiated on [DATE] for Resident 1 included, but were not limited to, oxygen at 2 liters per minute every shift, change oxygen tubing, humidity, clean oxygen concentrator, and clean filter once a day on Sundays. A Medication Administration Record for Resident 1, dated [DATE], indicated oxygen tubing was changed and the concentrator and filters were cleaned on [DATE], 15, 22, and 29, 2026. During an observation and interview with the Unit Manager on [DATE] at 9:52 A.M., she confirmed the oxygen concentrator and filter were dusty and dirty. The Unit Manger indicated the concentrator should have been most recently cleaned on Sunday, [DATE], and should have been cleaned weekly on Sundays. 2. During an observation, on [DATE] at 2:01 P.M., Resident 61 was noted with an undated oxygen tubing connected to her nasal cannula, connected to a portable oxygen tank behind her wheelchair. There was an empty, clear plastic bag, dated [DATE] hanging behind her wheelchair. The clinical record of Resident 61 was reviewed on [DATE] at 11:42 A.M. The resident's diagnoses included, but were not limited to: acute on chronic diastolic congestive heart failure, metabolic encephalopathy, cellulitis of left lower limb, sepsis, chronic obstructive pulmonary disease, morbid obesity, acute on chronic respiratory failure, paroxysmal atrial fibrillation, peripheral vascular disease, pulmonary hypertension, chronic kidney disease, obstructive sleep apnea, hypertension and glaucoma. Physician Orders, dated [DATE], included the following: change [the] oxygen tubing and humidity, clean concentrator and filter once a day on Sunday during the night shift. During an interview, on [DATE] at 10:50 A.M., the Regional Nurse Consultant (RNC) indicated she had checked for expired oxygen tubing in Resident 61's room on [DATE]. On [DATE] at 12:28 P.M., the Executive Director provided a policy titled, Oxygen Therapy and Devices, undated and indicated the policy was the one currently used by the facility. The policy indicated - .Concentrators and their filters should be maintained for optimal function.Oxygen devices.Nasal cannula.change out weekly and PRN. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:28 P.M., the Executive Director provided a policy titled, Oxygen Concentrator, undated, and indicated the policy was the one currently used by the facility. The policy indicated, .Clean the air inlet filter PRN and weekly. 3.1-47(a)(6)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow a monitor medications for 1 of 5 residents whose medications were reviewed. (Resident 3)Finding includes:Resident 3's record review was completed on 3/27/2026 at 9:15 A.M. Diagnoses included but were not limited to: dementia, major depressive disorder, morbid obesity, congestive heart failure, hypothyroidism and type 2 diabetes mellitus.Review of the physician's orders for medications for Resident 3 indicated the resident was to receive the following diabetic medications: Freestyle [NAME] insulin 5 units three times a day, Jardiance 10 mg tablet once daily and Insulin Glargine 20 units sq once a day. In addition, the resident was receiving the following medication to address thyroid issues: Levothyroxine 100 mcg once daily. A Physician's order, dated 3/20/2026, indicated Resident 3 had a blood laboratory order to have his hemoglobin A1C (measures average blood sugar levels) and thyroid-stimulating hormone (measures thyroid levels) tested.Resident 3's record lacked the documentation to indicate his laboratory orders had been completed.During an interview on 3/31/2026 at 12:30 P.M., the Director of Nursing (DON) indicated Resident 3 had not had his laboratory orders completed. The DON indicated the facility processes laboratory orders daily and Resident 3 had not had his laboratory order completed timely.On 3/31/2026 at 1:00 P.M., the Executive Director (ED) provided a policy dated 4/2024 and titled, Guidelines for Lab and Radiology Tracking. The ED indicated it was the policy currently used by the facility. The policy indicated, .Confirm that each lab and/or radiology test due has been obtained.410 IAC 3.1-48(a)(1)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on interview and record review, the facility failed to ensure an order for oral surgery was transcribed timely and followed timely for 1 of 19 residents who were reviewed. (Resident 3)Finding includes:During an interview on 3/25/2026 at 11:19 A.M., Resident 3 indicated he was scheduled for oral extractions for that day, but the procedure had been cancelled because the facility had not held his medication. Resident 3's record review was completed on 3/27/2026 at 9:15 A.M. Diagnoses included but were not limited to: dementia, major depressive disorder, morbid obesity, congestive heart failure and type 2 diabetes mellitus.Pre-Surgical Procedure/Surgery Instructions from a local oral surgery center dated, 3/10/2026, indicated Resident 3 was scheduled for oral surgery on 3/25/2026. The instructions indicated the facility was to hold the resident's scheduled doses of Jardiance four days prior to his surgery.A current Physician's order dated, 10/17/2024, indicated Resident 3 had been receiving 10 mg tablet of Jardiance once a day.A review of Resident 3's March 2026 Medication Administration Record indicated Resident 3 had been administered the Jardiance medication on March 21, 22, 23 and 24, 2026.A Nursing Note dated 3/24/2026 at 2:13 P.M. indicated Resident 3's oral extractions scheduled for 3/25/2026 were cancelled due to the Jardiance medication not being held prior to the procedure.During an interview on 3/27/2026 at 9:30 A.M., Unit Manager (UM) 6 indicated the facility had received a fax from the oral surgery center with orders to hold Resident 3's Jardiance four days prior to the procedure, but the orders on the fax had not been transcribed into the resident's Electronic Medical Record.A policy for following the Physician's orders was requested on 3/27/2026 at 10:00 A.M., but the Regional Nurse Consultant indicated the facility did not have a policy for following the Physician's orders. 410 IAC-3.1-24-(a)(1)