

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/01/2026	
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF BEDFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 3008 SHAWNEE DR S, BEDFORD, , 47421					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: August 31 and September 1, 2026 Facility number: 004011 Residential Census: 44 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 2, 2026.	R 0000					

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R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a minimum of one employee with a current First Aid (FA) certification on each shift for 3 of 7 days reviewed .	R 0117	"Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the facility with the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and submitted to comply with State requirements." What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this deficient practice. All residents had potential to be affected. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected by this deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	09/25/2026
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	Findings include: On 8/31/26 at 11:00 a.m., the BOM (Business Office Manager) provided the schedule and copies of the CPR (Cardiopulmonary Resuscitation) and FA certifications for the week 8/25/26 through 8/31/26. The schedule indicated the following: - On 8/26/26, there were no staff members on evening and night shift with FA certification. - On 8/27/26, there were no staff members on evening and night shift with FA certification. - On 8/31/26, there were no staff members on evening and night shift with FA certification. During an interview on 8/31/26 at 3:00 p.m., the BOM indicated there were no staff with FA certification on the evening and night shifts of 8/26/26, 8/27/26, and 8/31/26 On 9/1/26 at 11:10 a.m., the interim Administrator indicated they did not have a CPR and FA policy. The facility followed the state regulations.		All staff will be first aide and CPR certified by 9/22/2026. All new team members will rec first aid and CPR training during initial orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; All staff CPR/First aid cert will be audited weekly for 2 months, then monthly thereafter. By what date the systemic changes for each deficiency will be completed. 9/25/2026	
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5)	R 0217	"Preparation and/or execution of the Plan of Correction does not constitute admission or	09/25/2026

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	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be		agreement by the facility with the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and submitted to comply with State requirements." What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All resident service plans were audited to ensure service plans were signed and dated by resident or resident POA. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All resident service plans will be reviewed by the Executive director or designee to ensure service plans are signed and dated. All service plans will be reviewed and signed by ED after Res/RP signatures quarterly.	
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	involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were signed and dated by the resident or resident's representative for 1 of 7 residents reviewed for service plan signatures. (Resident 2) Findings include: On 8/31/26 at 2:15 p.m., Resident 2's clinical record was reviewed. The diagnoses included, but were not limited to, anemia (a condition in which the body does not have enough healthy red blood cells) and anxiety. The the resident's Admission ISP (Individual Service Plan)/LOC (Level of Care) Assessment, dated 7/24/26 was not signed or dated by the resident or resident's representative. During an interview with the interim Executive Director (ED) on 9/1/26 at 11:08 a.m., she indicated the resident's ISP had not been signed by the resident or the resident's representative. The interim ED indicated they do not have access to a policy for service plans, she indicated they followed state regulations		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; All new residents are reviewed upon admission. Weekly audit for 2 months, the monthly thereafter. By what date the systemic changes for each deficiency will be completed. 9/25/2026	
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	and guidance.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure a resident had an annual health statement for 1 of 7 residents reviewed. (Resident 4) Findings include: On 8/31/26 at 2:45 p.m., Resident 4's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes and hypertension (high blood pressure). The clinical record lacked an annual health statement indicating Resident 4 was free of communicable diseases. During an interview on 9/1/26 at 11:25 a.m., the interim Executive Director indicated the health statement was not in the clinical record for Resident 4. She indicated the facility did not	R 0409	"Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the facility with the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and submitted to comply with State requirements." What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All resident clinical records were audited to ensure that an annual health statement indicating residents is free from communicable diseases was signed by Physician. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All resident clinical records will be reviewed by the Executive	09/25/2026

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FORM APPROVED

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OMB NO. 0938-0391

have access to the policy for annual health statements, she indicated they followed state regulations and guidelines.

director, or designee to ensure that an annual health statement indicating residents is free from communicable diseases and is signed by Physician. PCPs will sign orders quarterly

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;

All new residents are reviewed upon admission. Weekly audit for 2 months, the monthly thereafter.

By what date the systemic changes for each deficiency will be completed.

9/25/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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

TITLE Executive Director

(X6) DATE 09/21/2026