STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK OF BEDFORD	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: November 29 & 30, 2021 Facility number: 004011 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on December 03, 2021.	R 0000		
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire	R 0092	1. On 11/19/2021, Executive Director conducted a fire drill with no concerns identified. 2. An audit of 2021 fire drill logs were completed on 11/19/2021 by Executive Director with no additional fire	01/15/2022

	alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure twelve fire drills were performed the past year for 43 of 43 residents who resided in the nursing facility. Findings include: On 11/29/2021 at 11:30 a.m., the facility fire drill log was reviewed. The log indicated there were no fire drills held in the facility for May 2021 and June 2021. There were 10 fire drills held in the last 12 months. During an interview, on 11/29/2021 at 12:35 p.m., the		drills omitted. 3. The newly hired (7/2021) Executive Director was re-trained by Regional Director of Care Services on 12/13/2021 regarding the fire drill regulation requirement. Attachment 1 4. The Executive Director is responsible for sustained compliance. The Executive Director or designee will audit the fire drill log monthly for 3 months to ensure fire drills are completed per regulatory requirement. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. 5. Completion date: January 15, 2022	

Administrator indicated there were no fire drills in the facility for May 2021 and June 2021, due to not having had a maintenance man nor an Administrator.

On 11/20/2021 at 1:40 p.m., the Administrator provided the facility's policy, "Fire, Wildfire, Explosion, Natural Gas Leak, Hazardous Spill" undated, and indicated this was the policy currently being used by the facility. A review of the policy indicated, "... Fire Drills ... Fire Drills will be conducted by ED [Executive Director], Nurse or designated alternate at least quarterly for each shift. ..."

The facility policy lacked documentation of the requirement of needing twelve fire drills every year.

Based on interview and record review, the facility failed to ensure twelve fire drills were performed the past year for 43 of 43 residents who resided in the nursing facility.

Findings include:

On 11/29/2021 at 11:30 a.m., the facility fire drill log was reviewed. The log indicated there were no fire drills held in the facility for May 2021 and June 2021. There were 10 fire drills held in the last 12 months.

During an interview, on

	11/29/2021 at 12:35 p.m., the Administrator indicated there were no fire drills in the facility for May 2021 and June 2021, due to not having had a maintenance man nor an Administrator. On 11/20/2021 at 1:40 p.m., the Administrator provided the facility's policy, "Fire, Wildfire, Explosion, Natural Gas Leak, Hazardous Spill" undated, and indicated this was the policy currently being used by the facility. A review of the policy indicated, "... Fire Drills ... Fire Drills will be conducted by ED [Executive Director], Nurse or designated alternate at least quarterly for each shift. ..." The facility policy lacked documentation of the requirement of needing twelve fire drills every year.			
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	R 0117	1. On 11/29/2021, the Executive Director reviewed and updated staffing schedule to ensure minimum of one employee with current CPR and first aid certification was present on each shift. 2. An audit of employee first aid/CPR certification was completed on 11/29/2021 by the Executive Director.	01/15/2022

	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 record review, the facility failed to ensure a minimum of 1 employee with a current First Aid (FA) certification on each shift for 7 of the 7 days for 43 of 43 residents who reside at the facility. Findings include: On 11/30/21 at 11:40 A.M., the Executive Director (ED) provided the schedule for the week of 11/21/21-11/27/21 and copies of FA certification cards for employees on the schedule for the week reviewed. A review of the nurses' and certified nursing assistants' schedule, dated 11/21/21-11/27/21, indicated there were no staff members on		Employees without current first aid/CPR certification will obtain certification by 12/3/2021. Attachment 3. The Executive Director was re-trained by Regional Director of Care Services on 12/13/2021 regarding the first aid/CPR regulation requirement. Attachment 2 4. The Executive Director is responsible for sustained compliance. The Care Services Manager or designee will audit the staffing schedule weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure a first aid/CPR certified employee is always on site. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. 5. Completion date: January 15, 2022	

	third shift who were FA certified for the following dates: 11/21/21 11/22/21 11/23/21 11/24/21 11/25/21 11/26/21 11/27/21 On 11/30/21 at 4:23 P.M., the CSM provided documentation of certification for Basic Life Saving and Cardiopulmonary Resuscitation for staff scheduled for third shift for the aforementioned dates. No certification for First Aid for those staff was provided. Based on record review, the facility failed to ensure a minimum of 1 employee with a current First Aid (FA) certification on each shift for 7 of the 7 days for 43 of 43 residents who reside at the facility. Findings include:			

	On 11/30/21 at 11:40 A.M., the Executive Director (ED) provided the schedule for the week of 11/21/21-11/27/21 and copies of FA certification cards for employees on the schedule for the week reviewed. A review of the nurses' and certified nursing assistants' schedule, dated 11/21/21-11/27/21, indicated there were no staff members on third shift who were FA certified for the following dates: 11/21/21 11/22/21 11/23/21 11/24/21 11/25/21 11/26/21 11/27/21 On 11/30/21 at 4:23 P.M., the CSM provided documentation of certification for Basic Life Saving and Cardiopulmonary Resuscitation for staff scheduled for third shift for the aforementioned dates. No certification for First Aid for those staff was provided.			
R 0273	Food and Nutritional Services - Deficiency	R 0273	1. The cottage cheese and honey mustard were discarded on	01/15/2022

	410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure that cottage cheese and honey mustard were discarded based on the manufacturer's use by date. Findings include: During observations of the facility kitchen on 11/29/21 at 10:00 a.m., the refrigerator contained 1 unopened cottage cheese and 1 opened cottage cheese each with a manufacturer's use by date of 11/20/21, and 1 opened honey mustard with a manufacturer's use by date of 9/20/21. During an interview, on 11/29/21 at 10:01 am, the Dietary Manager indicated the foods were expired and should have been discarded on or before the manufacturer's use by date. A review of the Retail Food Establishment Sanitation Requirement Book, dated effective November 13, 2004, indicated that foods should be discarded if the manufacturer's use-by date has been exceeded		11/29/2021 by dietary manager. Dietary manager was retrained by the Executive Director on 11/29/2021 on the proper procedure for disposing of expired food. Attachment 2. An audit of kitchen was done on 12/13/2021 by the Executive Director to ensure no outdated food present. No issues identified. Attachment 3. Staff was retrained on 11/29/2021 by the Executive Director regarding food disposal. Attachment 4. The Dietary Manager is responsible for sustained compliance. The Executive Director or designee will conduct observational audits of the kitchen 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks to ensure safe food handling is maintained, including food be discarded by the manufacturers use by date. Results of the audits will be discussed in the monthly QI meetings. The QI Committee will determine if	

	in accordance with food safety regulations. Based on observation, interview, and record review, the facility failed to ensure that cottage cheese and honey mustard were discarded based on the manufacturer's use by date. Findings include: During observations of the facility kitchen on 11/29/21 at 10:00 a.m., the refrigerator contained 1 unopened cottage cheese and 1 opened cottage cheese each with a manufacturer's use by date of 11/20/21, and 1 opened honey mustard with a manufacturer's use by date of 9/20/21. During an interview, on 11/29/21 at 10:01 am, the Dietary Manager indicated the foods were expired and should have been discarded on or before the manufacturer's use by date. A review of the Retail Food Establishment Sanitation Requirement Book, dated effective November 13, 2004, indicated that foods should be discarded if the manufacturer's use-by date has been exceeded in accordance with food safety regulations.		continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. 5. Completion date:January 15, 2022	

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