STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK OF BLOOMINGTON	2770 S ADAMS RD, BLOOMINGTON, , 47403

(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: February 7 and 8, 2023 Facility number: 004016 Residential Census: 59 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 9, 2023.	R 0000		
R 0026	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(a) (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their	R 0026	1. What Corrective action will be accomplished for those residents found to have been affected by the deficient practice On 2/20/2023, The Executive Director updated the resident rights posting on the wall in the lobby and provided	02/20/2023

	implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on observation, interview, and record review, the facility failed to ensure a copy of the residents' rights were available in a publicly accessible area. This had the potential to affect 59 of 59 residents. Finding includes: On 2/7/23 at 3:00 p.m., no posting of residents' rights was observed in the facility. On 2/8/23 at 10:30 a.m., no posting of the residents' rights was observed in the facility. A large sign was posted in the foyer entry, across from the Business Office desk. The sign was titled, "Resident Rights for Housing with Services Establishments." The sign did not include the Residents'		printed copies with telephone numbers to ensure easy accessibility for the residents in the lobby. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Executive Director lowered the residents rights wall hanging in the lobby and provided printed copies with telephone numbers to ensure public accessibility for the residents and visitors in the lobby on 2/20/2023. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur The Executive Director was re-educated by Regional Director of Care Services on 2/17/2023 on resident rights postings (See Attachment 1). 4. How the corrective action will be monitored to ensure the deficient	

	Rights. On 2/8/23 at 10:45 a.m., the Executive Director (ED) provided a copy of the facility's policy, "Resident Rights Policy," dated 3/1/22, and indicated it was the policy currently being used. A review of the policy did not indicate the residents' rights were to be available in a publicly accessible area. During an interview at that time, the ED indicated the large sign did not include the Indiana residents' rights and there was no posting of the rights in the facility. Based on observation, interview, and record review, the facility failed to ensure a copy of the residents' rights were available in a publicly accessible area. This had the potential to affect 59 of 59 residents. Finding includes: On 2/7/23 at 3:00 p.m., no posting of residents' rights was observed in the facility. On 2/8/23 at 10:30 a.m., no posting of the residents' rights was observed in the facility. A large sign was posted in the foyer entry, across from the Business Office desk. The sign was titled, "Resident Rights for Housing with Services Establishments." The sign did not include the Residents' Rights.		practice will not recur, what quality assurance program will be put into place The Executive Director is responsible for sustained compliance. The Care Services Manager or designee will ensure the resident rights poster is in the proper position weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure all residents have access to the resident rights and the appropriate phone numbers. 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 2/20/2023	

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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	R 0117	1. What Corrective action will be accomplished for those residents found to have been affected by the deficient practice On 2/20/2023, 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. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken An audit of employee first aid/CPR certification was completed on 2/20/2023 by the Executive Director.	02/28/2023

	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 1 employee with a current First Aid (FA) certification on each shift for 3 of 7 days reviewed. This had the potential to affect 59 of 59 residents who resided at the facility. Findings include: On 2/7/23 at 2:30 p.m., the Executive Director provided the schedule for the week 2/1/23 through 2/7/23. On 2/8/23 at 9:00 a.m., the Executive Director presented copies of the CPR and FA certifications for the employees on the schedule for the week reviewed. Review of the nurses and certified nursing assistant's schedule, dated 2/1/23 through 2/7/23 indicated the following: -On 2/3/23, there were no staff members on 11:00 p.m. through 6:00 a.m. shift that were FA certified.		Employees without current first aid/CPR certification will obtain certification by 2/28/2023. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur The Executive Director was re-trained by Regional Director of Care Services on 2/17/2023 regarding the first aid/CPR regulation requirement. (See Attachment 1) 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place 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/CPT certified employee is always on site. The audits will be discussed at monthly QI meetings. The QI	

	-On 2/4/23, there were no staff members on 6:00 p.m. through 6:00 a.m. shift that were FA certified. -On 2/7/23, there were no staff members on 11:00 p.m. through 6:00 a.m. shift that were FA certified. During an interview on 2/8/23 at 10:50 a.m., the Executive Director indicated she had presented all the FA cards. The shifts on 2/3/23, 2/4/23, and 2/7/23 lacked staff with FA certifications. On 2/8/23 at 11:11 a.m., the Executive Director indicated the facility did not have a FA policy. The facility refers to the state regulations. Based on interview and record review, the facility failed to ensure a minimum of 1 employee with a current First Aid (FA) certification on each shift for 3 of 7 days reviewed. This had the potential to affect 59 of 59 residents who resided at the facility. Findings include: On 2/7/23 at 2:30 p.m., the Executive Director provided the schedule for the week 2/1/23 through 2/7/23. On 2/8/23 at 9:00 a.m., the Executive Director presented copies of the CPR and FA		Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on going 5. Completion date 2/28/2023	

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R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f)	R 0273	1. What Corrective action will be accomplished for those residents found to have been affected by	02/28/2023

(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 thawing meat was labeled and stored in a manner to prevent potential cross contamination, potentially affecting 59 of 59 residents served from the kitchen.

Findings include:

On 2/8/23 at 10:30 a.m., a 15 pound pork roast was observed on the bottom shelf of the kitchen refrigerator. There was no label on the roast to indicate what day and time the roast was placed in the refrigerator. Beneath and around the roast was a pool of reddish colored liquid consistent with liquid purged from thawing meat.

During an interview on 2/8/23 at 10:35 a.m., the Dietary Manager indicated the roast lacked a label to indicate what date and what time it was placed in the refrigerator for thawing. The reddish liquid was in need of removal, and the roast placed in a tray to prevent the liquid from contaminating the refrigerator shelf or other food items in the refrigerator.

During an interview on 2/8/23 at

the deficient practice

Dietary
Manager and Assistant Chef will correctly label thawing meat with date, and
time each time thawing meat is placed in the refrigerator. The thawing
meat will be placed in a stainless-steel container in the refrigerator to
prevent cross contamination.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective
action will be taken

On 2/17 a full house audit was completed by
Chef. At that time there was no thawing
meat. All stored meat was labeled
correctly. The Chef and Assistant Chef
will continue to monitor the labeling and storing of thawing meat in stainless
steel container in the refrigerator daily.

3. What measures will be put into place or what systemic changes
the facility will make to ensure that the deficient practice does not recur

	11:10 a.m., the facility Administrator indicated the roast needed to have had a label indicating the date and time it was placed in the refrigerator to thaw. It should have been on a tray rather than the refrigerator shelf itself. On 2/8/23 at 11:20 a.m., the facility Administrator provided the facility Storage of Products policy, dated 4/17/17 and indicated this was the policy used by the facility. A review of the policy indicated, "...potentially hazardous foods such as eggs or thawing meat...in separate pans for thawing to prevent cross contamination..." Based on observation, interview, and record review, the facility failed to ensure thawing meat was labeled and stored in a manner to prevent potential cross contamination, potentially affecting 59 of 59 residents served from the kitchen. Findings include: On 2/8/23 at 10:30 a.m., a 15 pound pork roast was observed on the bottom shelf of the kitchen refrigerator. There was no label on the roast to indicate what day and time the roast was placed in the refrigerator. Beneath and around the roast was a pool of reddish colored liquid consistent with liquid		On 2/17/2028, Executive Director was re-educated on state requirements and Enlivant requirements for labeling food and thawing food by the regional director of care services (See Attachment 1). Executive Director re-trained Chef and Assistant Chef on state requirements and Enlivant requirements for labeling food and thawing food. (See Attachment 2) 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place Executive Director will audit for compliance weekly for 4 weeks, biweekly for 4 weeks, and monthly for 1 month. 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. 5. Completion 2/28/2023.	

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SIGNATURE		