STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/08/2025

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: October 7 and 8, 2025 Facility number: 004016 Residential Census: 40 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed October 10, 2025.	R 0000	Please see attached plan of correction. ***Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency***	

R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview, and record review, the facility failed to ensure the insulin pen was labeled with the open date for 1 of the 2 medications carts observed. Findings include: On 10/7/25 at 11:47 a.m., Qualified Medication Aide (QMA) 1 was observed to have Resident 5's insulin lispro insulin pen. The insulin pen lacked a	R 0301	***Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency*** **R -301 410IAC 16.2-5-6(C)(5) Pharmaceutical Services – Deficiency** **1. What**	10/10/2025

date the pen was opened. At that time, QMA 1 indicated the pen was to have an open date.

On 10/8/25 at 11:55 a.m., the Director of Nursing (DON) provided the facility's policy, Medication Storage Policy and Procedures," dated 8/30/24 and indicated it was the policy being used by the facility. A review of the policy lacked documentation of dating opened insulin syringe.

Based on observation, interview, and record review, the facility failed to ensure the insulin pen was labeled with the open date for 1 of the 2 medications carts observed.

Findings include:

On 10/7/25 at 11:47 a.m., Qualified Medication Aide (QMA) 1 was observed to have Resident 5's insulin lispro insulin pen. The insulin pen lacked a date the pen was opened. At that time, QMA 1 indicated the pen was to have an open date.

On 10/8/25 at 11:55 a.m., the Director of Nursing (DON) provided the facility's policy, Medication Storage Policy and Procedures," dated 8/30/24 and indicated it was the policy being used by the facility. A review of the policy lacked documentation of dating opened insulin syringe.

corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

The resident identified as being affected
had an insulin pen that had been opened the same day but was not labeled with
the open date. Upon identification the insulin pen was immediately labeled with
the correct open date to ensure compliance with medication storage and labeling requirements. All
LPN's and QMA's have been re-educated on labeling and storage of medication and insulin on October 9th and 10th, 2025 by our Director of Nursing.

**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:**

All residents had the potential to be affected.
All LPN's and QMA's have been re-educated on labeling and storage of prescription drugs; with resident's full name, physicians name, prescription number, name and

strength of the drug, directions for use, date of issue and expiration date, name and address of pharmacy that filled prescription and date opened. Education dates were October 9th and 10th, 2025 by our Director of Nursing.

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

All LPN's and QMA's were re-educated on the facility's policy regarding medication and insulin storage labeling requirements, including the requirement to label all insulin pens with the date opened immediately upon first use. The Director of Nursing or designee will conduct random audits of insulin pens 3 times weekly for 4 weeks, then 1 time a week for 1 month to ensure continued compliance.

4. 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: The Director of Nursing or designee will monitor compliance with insulin labeling procedures through random audits of medication carts and refrigerators 3 times weekly for 4 weeks, then 1 time a week for 1 month, and monthly thereafter. Any noncompliance identified will be immediately corrected and re-education provided as needed. Audit results will be reported and reviewed during QI meetings. The QI committee will determine if continued auditing is necessary based on 3 months of compliance. Monitoring will be ongoing. **5. By what date will the systemic changes be completed?** October 10, 2025	

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	TITLEExecutive Director	(X6) DATE10/22/2025

SIGNATURETamara Vaughn		