STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK OF SEYMOUR	2288 NICHOLAS CT, SEYMOUR, , 47274

(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 15, and 16, 2025 Facility number: 004376 Residential Census: 16 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 20, 2025.	R 0000		
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation,	R 0247	R247 HEALTH SERVICES DEFICENCY 1: What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice? - No residents were found to have been affected by the deficient practice.	11/04/2025

	interview, and record review, the facility failed to administer insulin according to the manufacturer's guidelines for 1 of 5 residents reviewed for medication administration. (Resident 113) Findings include: Medication administration for Resident 113 was observed on 10/15/2025 at 11:28 A.M., with Qualified Medication Aide (QMA) 2. The resident had a blood glucose test value of 166 and was to receive two units of Novolog insulin along with a scheduled dose of 28 units of Novolog insulin for a total of 30 units. The QMA retrieved the Novolog insulin pen from a refrigerator in the medication room, removed the pen cap, cleaned the hub of the pen with an alcohol wipe, and applied a new needle. She turned the dosage knob on the end of the insulin pen to two units to prime the pen, removed the needle cap, aimed the pen downward over the sink, and squirted the insulin into the sink. She then turned the dosage knob to 30 units, handed the pen to the resident, and the resident administered the insulin into his abdomen. During an interview on 10/15/2025 at 11:42 A.M., QMA 2 indicated insulin pens were primed to remove any air		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? - Any resident who received insulin had the potential to be affected by this deficient practice. The ED/DON will complete initial insulin competency check offs with med passers then monthly for 4 months. 3: What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not re occur. - The ED/DON will complete initial insulin competency check offs with med passers then monthly for 4 months. 4: How the corrective actions will be monitored to ensure the deficient practice will not recur. i.e. what quality assurance program will be put into place? The corrective actions will be monitored by the ED, DON or designee. The corrective actions will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 4 consecutive months of compliance. Monitoring will be on going.	

	bubbles that may be in the pen. She had aimed the pen downward into the sink so the insulin would not go out of the sink. The Face Sheet for Resident 113 was provided by the Administrator on 10/15/2025 at 11:59 A.M. The resident's diagnoses included, but were not limited to, diabetes, hypertension, and heart failure. The Novolog insulin package insert was provided by the Administrator on 10/15/2025 at 11:59 A.M. The instructions for use indicated, "...Priming...Pen...Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top...Hold the Pen with the needle pointing up. Press and hold the dose button until the dose counter shows "0"...A drop of insulin should be seen at the needle tip..." The current "Medication Administration Policy & Procedure", dated 09/27/2024, was provided by the Administrator on 10/15/2025 at 11:59 A.M. The policy indicated, "...Medications are administered by a licensed nurse or delegated staff who are medication trained..." Based on observation, interview, and record review, the		5: What date will the systemic changes be completed? - 11/4/2025	

	facility failed to administer insulin according to the manufacturer's guidelines for 1 of 5 residents reviewed for medication administration. (Resident 113) Findings include: Medication administration for Resident 113 was observed on 10/15/2025 at 11:28 A.M., with Qualified Medication Aide (QMA) 2. The resident had a blood glucose test value of 166 and was to receive two units of Novolog insulin along with a scheduled dose of 28 units of Novolog insulin for a total of 30 units. The QMA retrieved the Novolog insulin pen from a refrigerator in the medication room, removed the pen cap, cleaned the hub of the pen with an alcohol wipe, and applied a new needle. She turned the dosage knob on the end of the insulin pen to two units to prime the pen, removed the needle cap, aimed the pen downward over the sink, and squirted the insulin into the sink. She then turned the dosage knob to 30 units, handed the pen to the resident, and the resident administered the insulin into his abdomen. During an interview on 10/15/2025 at 11:42 A.M., QMA 2 indicated insulin pens were primed to remove any air bubbles that may be in the pen.			

	She had aimed the pen downward into the sink so the insulin would not go out of the sink. The Face Sheet for Resident 113 was provided by the Administrator on 10/15/2025 at 11:59 A.M. The resident's diagnoses included, but were not limited to, diabetes, hypertension, and heart failure. The Novolog insulin package insert was provided by the Administrator on 10/15/2025 at 11:59 A.M. The instructions for use indicated, "...Priming...Pen...Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top...Hold the Pen with the needle pointing up. Press and hold the dose button until the dose counter shows "0"...A drop of insulin should be seen at the needle tip..." The current "Medication Administration Policy & Procedure", dated 09/27/2024, was provided by the Administrator on 10/15/2025 at 11:59 A.M. The policy indicated, "...Medications are administered by a licensed nurse or delegated staff who are medication trained..."			
R 0273	Food and Nutritional Services - Deficiency	R 0273	R 273 FOOD AND NUTRITIONAL SERVICES	11/04/2025

	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 food was stored properly and ensure the dishwasher functioned according to the manufacturer's guidelines. This deficient practice had the potential to effect 16 of 16 residents that reside in the facility. Findings include: The facility kitchen was observed with Cook 3 on 10/15/2025 at 10:20 A.M. Cook 3 indicated she was the only staff member in the kitchen. She was standing at a table preparing a dessert for lunch. There was a fly buzzing around the table as she mixed the ingredients in a bowl. During the initial tour, the following was observed: - A refrigerator contained a nearly full gallon jug of cider. The jug was sticky, and a dead fly was stuck to the outside of the jug. - The back door to the kitchen		DEFICENCY 1: What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice? - Kitchen staff will be in-serviced on kitchen sanitation and proper food storage. Kitchen will incorporate weekly refrigerator clean out to ensure no insects in refrigerator. All staff in-service to be completed regarding propping back door open. Back doorstop will be removed from back kitchen door. 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 by this deficient practice. Kitchen staff will be in-serviced on kitchen sanitation and proper food storage. Kitchen will incorporate weekly refrigerator clean out to ensure no insects in refrigerator. All staff in-service to be completed regarding propping back door open and ensuring dish machine is temping at 120 degrees before dishes are washed. Back doorstop will be removed from back kitchen door. ED or designee will complete weekly audits to	

was propped all the way open. The facility dumpster was located directly outside and to the left, about 10 to 15 feet from the door.

During an interview, on 10/16/2025 at 9:50 A.M., Cook 3 indicated the kitchen door should not be propped open.

The dry storage area was observed and contained the following items:

- A large square container with a blue lid that was 1/3 full of sugar. The blue lid was completely off the container and sitting on top of a container next to the sugar.

- A small square container with a red lid that was about 1/3 full of salt. The red lid was on top of the container but was not pushed down all the way, leaving a 1/2 inch gap between the lid and the entire front of the container.

During an interview, on 10/15/2025 at 10:29 A.M., Cook 3 indicated the lid was left off the sugar from when she had prepared the sweet tea earlier that morning.

The dishwasher was observed with Cook 3 on 10/16/2025 at 9:48 A.M. The information plate on the machine indicated it was a low temperature dishwasher and the wash and rinse

ensure compliance.

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

- Ongoing staff education. Removal of back door stop. Auditing kitchen on regular basis to ensure ongoing compliance.

4: How the corrective actions will be monitored to ensure the deficient practice will not recur. i.e. what quality assurance program will be put into place?

- The ED or Designee will complete kitchen audits weekly x4 weeks, then monthly x4 weeks.

5: What date will the systemic changes be completed?

- 11/4/2025

temperatures needed to reach 120 degrees Fahrenheit (F). Cook 3 ran a dishwashing cycle, and the temperature only reached 110 degrees F.

During an interview, on 10/16/2025 at 9:50 A.M., Cook 3 indicated they always had to run the dishwasher several times to get the dishwasher hot. She thought the temperature needed to reach 170 degrees F. They did not document the dishwasher temperature anywhere. They were never instructed to document the temperature. They did document chemical strip tests to ensure the sanitizer levels were appropriate for the chlorine levels.

During a telephone interview, on 10/16/2025 at 9:52 A.M., the Kitchen Manager indicated the dishwasher needed to reach 120 degrees F. She was never instructed to document dishwasher temperatures. There were no logs of dishwasher temperatures.

The dishwasher was observed again with Cook 3 on 10/16/2025 at 12:25 P.M. The dishwasher needed to be ran four times before the temperature reached 120 F.

The current, undated facility policy, titled "Food Storage", was provided by the

Administrator on 10/16/2025 at 11:42 A.M. The policy indicated, "...inspect and ensure that all opened foods are properly dated and stored daily..."

The current manufacturer's instructions for the dishwasher, titled "American Dish Service", dated 04/28/2021, were provided by the Administrator on 10/16/2025 at 11:51 A.M. The instructions indicated, "...WATER HEATERS or boilers must provide the minimum temperature of 120F degrees required by the machine..."

Based on observation, interview, and record review, the facility failed to ensure food was stored properly and ensure the dishwasher functioned according to the manufacturer's guidelines. This deficient practice had the potential to effect 16 of 16 residents that reside in the facility.

Findings include:

The facility kitchen was observed with Cook 3 on 10/15/2025 at 10:20 A.M. Cook 3 indicated she was the only staff member in the kitchen. She was standing at a table preparing a dessert for lunch. There was a fly buzzing around the table as she mixed the ingredients in a bowl.

During the initial tour, the following was observed:

- A refrigerator contained a nearly full gallon jug of cider. The jug was sticky, and a dead fly was stuck to the outside of the jug.

- The back door to the kitchen was propped all the way open. The facility dumpster was located directly outside and to the left, about 10 to 15 feet from the door.

During an interview, on 10/16/2025 at 9:50 A.M., Cook 3 indicated the kitchen door should not be propped open.

The dry storage area was observed and contained the following items:

- A large square container with a blue lid that was 1/3 full of sugar. The blue lid was completely off the container and sitting on top of a container next to the sugar.

- A small square container with a red lid that was about 1/3 full of salt. The red lid was on top of the container but was not pushed down all the way, leaving a 1/2 inch gap between the lid and the entire front of the container.

During an interview, on 10/15/2025 at 10:29 A.M., Cook 3 indicated the lid was left off

the sugar from when she had prepared the sweet tea earlier that morning.

The dishwasher was observed with Cook 3 on 10/16/2025 at 9:48 A.M. The information plate on the machine indicated it was a low temperature dishwasher and the wash and rinse temperatures needed to reach 120 degrees Fahrenheit (F). Cook 3 ran a dishwashing cycle, and the temperature only reached 110 degrees F.

During an interview, on 10/16/2025 at 9:50 A.M., Cook 3 indicated they always had to run the dishwasher several times to get the dishwasher hot. She thought the temperature needed to reach 170 degrees F. They did not document the dishwasher temperature anywhere. They were never instructed to document the temperature. They did document chemical strip tests to ensure the sanitizer levels were appropriate for the chlorine levels.

During a telephone interview, on 10/16/2025 at 9:52 A.M., the Kitchen Manager indicated the dishwasher needed to reach 120 degrees F. She was never instructed to document dishwasher temperatures. There were no logs of dishwasher temperatures.

	The dishwasher was observed again with Cook 3 on 10/16/2025 at 12:25 P.M. The dishwasher needed to be ran four times before the temperature reached 120 F. The current, undated facility policy, titled "Food Storage", was provided by the Administrator on 10/16/2025 at 11:42 A.M. The policy indicated, "...inspect and ensure that all opened foods are properly dated and stored daily..." The current manufacturer's instructions for the dishwasher, titled "American Dish Service", dated 04/28/2021, were provided by the Administrator on 10/16/2025 at 11:51 A.M. The instructions indicated, "...WATER HEATERS or boilers must provide the minimum temperature of 120F degrees required by the machine..."			

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 SIGNATUREKatie Lucas	TITLEExecutive Director & Director of Nursing	(X6) DATE10/31/2025