STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK OF MUNCIE	2410 E MCGALLIARD RD, MUNCIE, , 47303

(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 Post Survey Revisit (PSR) to the Investigation of Residential Complaint IN00352955 completed on 6/3/21. This visit was in conjunction with the Investigation of Complaint IN00356958. Complaint IN00356958- Unsubstantiated, due to lack of evidence. Complaint IN00352955- Not corrected. State Residential Findings are cited at R0088. Survey dates: July 7 and 8, 2021 Facility number: 004428 Residential Census: 41 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review completed on July 13, 2021.			
R 0088	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator Based on interview and record review, the facility failed to delegate a Health facilities Administrator to oversee the daily operations of the facility. Findings Include:	R 0088	**R 088** **Administration and Management-noncompliance** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** On 7/21/2021, Regional Director of Operations extended an offer to an Administrator with a health facility administrator license. On 7/21/21, Administrator accepted offer and will be appointed the Administrator on record for facility effective 8/9/21. **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:**	08/10/2021

During an interview, on 7/7/21 at 10:55 a.m., Care Services Manager (CSM) indicated Executive Director 1 (ED 1) of the facility was off site. She indicated Executive Director 2 (ED 2) would be notified of the survey in progress.

During an interview, on 7/7/21 at 11:20 a.m., CSM indicated ED 2 was on her way to the facility.

During an interview, on 7/7/21 at 11:40 a.m., ED 2 indicated she was the ED Designee for Lynd Place and provided day-to-day Administrator operations duties for Lynd Place on site 2 to 3 days each week. She indicated she also provided day-to-day Administrator operations duties at another Indiana facility where her license was on record. ED 2 indicated staff at Lynd Place contacted her for any concerns that needed addressed by the Administrator 7 days a week. ED 2 indicated the Executive Director 1 (ED 1) on record had her license attached to Lynd Place and was also the Regional Director of Care Services.

Review of a "Key Personnel" document, provided by the facility on 7/7/21 at 11:40 a.m., indicated ED 1 was the Executive Director and ED 2 was the Designee.

During an interview, on 7/7/21 at

A licensed Administrator will provide onsite coverage at minimum 2
days per week and be available via phone 24 hours a day 7 days a week until
appointed Administrator takes over duties on 8/9/21.

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

By 8/9/21, the Care Service Manager will provide the name and
contact information of the appointed Administrator to current staff and
residents.

**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:**

By 8/9/21, facility will notify the Indiana State
Department of Health director of

	3:42 p.m., ED 2 indicated she was not certain how often ED 1 was on site at Lynd Place, as she was not there everyday. ED 2 indicated ED 2 was typically on site at Lynd Place on Tuesday and Thursday each week and she had not seen ED 1 on site at Lynd Place when she was there. Review of the Plan of Correction binder, provided by ED 2 on 7/7/21 at 3:48 p.m., indicated ED 1 was the New Administrator appointed for Lynd Place on 1/19/21. During an interview, on 7/7/21 at 4:42 p.m., Certified Nurse's Aide 3 (CNA 3) indicated she worked at Lynd Place for 2 years and has never met the lady who's license is over the building and she could not recall the name of ED 1. She indicated her point of contact for Administrator questions was ED 2. During an interview, on 7/7/21 at 4:49 p.m., Licensed Practical Nurse 1 (LPN 1) indicated during a recent in-service, the staff were educated that ED 1's license was attached to Lynd Place because ED 2 was not permitted to have her license attached to two buildings. LPN 1 indicated she contacted ED 2 for Administrator needs even when ED 2 was not on site. LPN 1 indicated she only contacted ED 1 when ED 2 was		the name and license number of the appointed administrator and will delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. Changes will be reviewed at monthly QI meeting. Monitoring will be on-going **5. By what date the systemic changes will be completed** Completion date: 8/10/2021	

unavailable.

During an interview, on 7/8/21 at 9:32 a.m., Licensed Practical Nurse 2 (LPN 2)indicated he was a full time staff member that worked both first and second shift. LPN 2 indicated ED 2 was the point of contact for Administrator needs at Lynd Place. LPN 2 indicated ED 1 was the Regional Care Service Manager and he had not seen ED 1 on site at Lynd Place during the last 2 weeks. LPN 2 indicated ED 2 was on site at Lynd Place each week on Tuesday and Thursday.

During an interview, on 7/8/21 at 9:40 a.m., Resident C indicated ED 2 was the Administrator at Lynd Place and she was only on site Tuesday and Thursday each week. He indicated on the other days of the week he had to notify other staff to contact ED 2 for any Administrator needs. Resident C indicated he did not have any knowledge of ED 1.

During an interview, on 7/8/21 at 9:46 a.m., Resident D indicated Lynd Place did not have an Administrator, but ED 2 was on site at Lynd Place on Tuesday and Thursday each week for Administrator needs. He indicated he had never heard of ED 1 nor had he met her.

During an interview, on 7/8/21 at

9:59 a.m., Housekeeper 1 indicated she worked first shift on Monday, Tuesday, Wednesday, and Friday. She indicated she had not seen ED 1 at the facility so she assumed ED 1 was at the facility on the days she was off. She indicated she contacted ED 2 for Administrator questions. Housekeeper 1 indicated ED 2 was on site at Lynd Place every Tuesday and Thursday.

During an interview, on 7/8/21 at 10:21 a.m., CSM indicated ED 1 did not work at Lynd Place on site full time. She indicated ED 2 was on site at Lynd Place 2 days each week. She indicated she had communications with ED 1 via Zoom (a video communication tool) at least 1 time each week but she had not seen ED 1 on site at Lynd Place since last month.

During a telephone interview, on 7/8/21 at 11:16 a.m., ED 1 indicated she worked full time for the corporation and she provided support to Lynd Place via Zoom, Email, and telephone 24 hours a day and 7 days a week. ED 1 indicated she had not been on site at the facility this week and she was unable to recall when she was last on site at Lynd Place. ED 1 indicated ED 2 was the Designee for Lynd Place and also provided day-to-day Administrator operations at

another facility where her license was on record.

During an interview, on 7/8/21 at 11:28 a.m., ED 2 indicated the facility did not have a policy regarding facility Administrator coverage and the facility followed State Regulations. She indicated ED 1 had 13 Communities in her region and ED 1's Administrator license was on record for Lynd Place.

Review of an "Administrator or Director of Nursing Change" form, provided by ED 2 on 7/8/21 at 12:20 p.m., indicated ED 1 was the New Administrator appointed for Lynd Place on 3/16/21.

This state residential finding relates to complaint IN00352955.

This deficiency was cited on 6/3/21. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on interview and record review, the facility failed to delegate a Health facilities Administrator to oversee the daily operations of the facility.

Findings Include:

During an interview, on 7/7/21 at 10:55 a.m., Care Services Manager (CSM) indicated Executive Director 1 (ED 1) of

the facility was off site. She indicated Executive Director 2 (ED 2) would be notified of the survey in progress.

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During an interview, on 7/7/21 at 3:42 p.m., ED 2 indicated she was not certain how often ED 1 was on site at Lynd Place, as she was not there everyday. ED

2 indicated ED 2 was typically on site at Lynd Place on Tuesday and Thursday each week and she had not seen ED 1 on site at Lynd Place when she was there.

Review of the Plan of Correction binder, provided by ED 2 on 7/7/21 at 3:48 p.m., indicated ED 1 was the New Administrator appointed for Lynd Place on 1/19/21.

During an interview, on 7/7/21 at 4:42 p.m., Certified Nurse's Aide 3 (CNA 3) indicated she worked at Lynd Place for 2 years and has never met the lady who's license is over the building and she could not recall the name of ED 1. She indicated her point of contact for Administrator questions was ED 2.

During an interview, on 7/7/21 at 4:49 p.m., Licensed Practical Nurse 1 (LPN 1) indicated during a recent in-service, the staff were educated that ED 1's license was attached to Lynd Place because ED 2 was not permitted to have her license attached to two buildings. LPN 1 indicated she contacted ED 2 for Administrator needs even when ED 2 was not on site. LPN 1 indicated she only contacted ED 1 when ED 2 was unavailable.

During an interview, on 7/8/21 at 9:32 a.m., Licensed Practical

Nurse 2 (LPN 2)indicated he was a full time staff member that worked both first and second shift. LPN 2 indicated ED 2 was the point of contact for Administrator needs at Lynd Place. LPN 2 indicated ED 1 was the Regional Care Service Manager and he had not seen ED 1 on site at Lynd Place during the last 2 weeks. LPN 2 indicated ED 2 was on site at Lynd Place each week on Tuesday and Thursday.

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During an interview, on 7/8/21 at

	11:28 a.m., ED 2 indicated the facility did not have a policy regarding facility Administrator coverage and the facility followed State Regulations. She indicated ED 1 had 13 Communities in her region and ED 1's Administrator license was on record for Lynd Place. Review of an "Administrator or Director of Nursing Change" form, provided by ED 2 on 7/8/21 at 12:20 p.m., indicated ED 1 was the New Administrator appointed for Lynd Place on 3/16/21. This state residential finding relates to complaint IN00352955. This deficiency was cited on 6/3/21. The facility failed to implement a systemic plan of correction to prevent recurrence. Based on interview and record review, the facility failed to delegate a Health facilities Administrator to oversee the daily operations of the facility. Findings Include:			

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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	TITLE	(X6) DATE