STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/27/2025

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 State Residential Licensure Survey. Survey dates: August 26 & 27 2025 Facility number: 004428 Residential Census: 44 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 3, 2025.	R 0000	R 000 INITIAL COMMENTS R 000 This visit was for a State Residential Licensure Survey. Survey dates: August 26 & 27 2025 Facility number: 004428 Residential Census: 44 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 3, 2025.	
R 0045	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that	R 0045	**R 045 410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights** • **What corrective action(s) will be**	09/22/2025

	the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is		**accomplished for those residents found to have been affected by the deficient practice** Resident 28 was readmitted to the community without any adverse effects resulting from failure to ensure transfer form was completed upon transfer in March and August 2025. • **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 being transferred out of the community have the potential to be affected by the same deficient practice • **What measures will be put into place or what**	

	transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If		**systemic changes will the facility make to ensure that the deficient practice does not recur.** Effective immediately, a face sheet containing pertinent information related to transfer will be sent with each resident upon transfer. All nursing personnel were informed of the updated transfer process. All nursing personnel were informed and educated on this process. **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; and** Nurse/designee will document in the medical records that the	

	you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on interview and record review, the facility failed to provide communication with the recieving facility for continuity of care for 1 of 1 residents reviewed for hospital transfer. (Resident 38) Finding includes:		emergency packet and the resident's transferred location were communicated to the appropriate party. All nursing personnel were informed and educated on this process. **By what date the systemic changes will be completed.** 9-22-25	

	Resident 28's record was reviewed on 8/27/25 at 10:51 a.m. Medical diagnoses included depression, hypertension (high blood pressure), and type two diabetes. A progress note dated 3/31/25 at 5:59 p.m. indicated the resident was away from the community "at er [at Emergency Room]" due to a fall. A progress note dated 3/31/25 at 8:15 p.m. indicated the resident returned from the hospital. A progress note dated 8/5/25 at 10:15 p.m. indicated the resident had a fall in her room around 7:15 p.m. and was sent to the hospital via ambulance. A progress note dated 8/6/25 at 12:00 a.m. indicated the resident returned from the emergency room (ER) and family was aware. The clinical record lacked communication with the receiving facility for transfers on 3/31/25 and 8/5/25. During an interview with the DON on 8/27/25 at 3:06 p.m., she indicated the facility did not utilize transfer forms. Face sheets were provided to emergency medical services (EMS). Staff were to document a change in status, but if she			

	was present for the transfer, she would have created a progress note. During an interview with QMAs 5 & 6 on 3/27/25 at 3:28 p.m., they indicated when a resident was transferred, they would have created an observation note detailing what happened and why the resident was transferred. They filled out a face sheet and gave it to EMS. During an interview with the DON on 8/27/25 at 3:59 p.m., she indicated she was the primary person who documented resident transfers. When a resident complained of pain or struck their head, Qualified Medication Aides (QMAs) and Certified Nurse Aides (CNAs) were to chart a status change and call 911. During an interview with the DON on 8/27/25 at 4:17 p.m., she indicated the facility did not have a policy regarding transfers. Based on interview and record review, the facility failed to provide communication with the recieving facility for continuity of care for 1 of 1 residents reviewed for hospital transfer. (Resident 38) Finding includes: Resident 28's record was reviewed on 8/27/25 at 10:51			

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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	*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*	09/22/2025

	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 a fire drill was completed on each shift quarterly to ensure resident safety in the event of a fire emergency. This deficiency had the potential to affect 44 of 44 residents in the facility. Finding includes: On 8/27/25 at 3:03 p.m., the interim Administrator indicated the Maintenance Director conducted all the fire drills and had access to all of them. A review of the fire drills conducted at the facility from		*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 092 410** **IAC 16.2-5-1.3(i)(1-2)** **Administration and** **Management** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** To ensure the safety of all residents affected by the deficient practice, the facility will conduct fire drills quarterly on each shift as required. The Maintenance Director will document and maintain records of all completed and scheduled fire drills to verify compliance	

October 2024 through August 2025 indicated the fire drills were held on the following dates and shifts: 10/31/24 - first shift, 12/9/24 - second shift, 1/15/25 first shift, 2/8/25 second shift, 4/29/25 - third shift, 4/29/25 - second shift, 5/24/25 - first shift, 5/28/25 - second shift, 6/26/25 - third shift, 7/23/25 - first shift, and 8/23/25 - first shift.

The record indicated the following: From October 2024 through December 2024, only first shift and second shift received a fire drill. From January 2025 through March 2025, only first shift and second shift received a fire drill.

On 8/27/25 at 3:14 p.m., the Maintenance Director indicated he had provided all of the fire drills held from October 2024 through August 2025. The facility had not conducted third shift fire drills in the last quarter of 2024 nor in the first quarter of 2025.

During an interview on 8/27/24 at 3:24 p.m., the Maintenance Director indicated he was required to conduct fire drills every month and alternating to include all shifts every quarter. He did not know why the fire drills were not conducted as required. In the event of a Maintenance Director vacancy, fire drills should have been delegated to another staff

and ensure
staff familiarity with emergency procedures.

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 the deficient practice. The Maintenance Director will ensure that fire drills are conducted as required and will
document and maintain records of all completed and scheduled drills to prevent
recurrence and ensure resident safety.

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:

The
Maintenance Director will provide the Executive Director with copies of all
fire drill documentation for each shift. Records will be reviewed together to
ensure all drills are completed, properly documented, and

member for completion.

A current facility policy, undated, titled "Staff In-Service and Fire Safety Training Policy & Procedures," provided by the Maintenance Director on 8/27/25 at 3:32 p.m., indicated the following: "Policy: Community staff shall be instructed and trained in various fire and life safety procedures and devices... Procedures: A fire drill or in-service staff training session is required on each shift, every month in the following schedule: 1) Fire Drill: Must be conducted once per quarter on each shift...."

Based on interview and record review, the facility failed to ensure a fire drill was completed on each shift quarterly to ensure resident safety in the event of a fire emergency. This deficiency had the potential to affect 44 of 44 residents in the facility.

Finding includes:

On 8/27/25 at 3:03 p.m., the interim Administrator indicated the Maintenance Director conducted all the fire drills and had access to all of them.

A review of the fire drills conducted at the facility from October 2024 through August 2025 indicated the fire drills were held on the following dates and shifts: 10/31/24 - first shift, 12/9/24 - second shift, 1/15/25

future drills are scheduled in accordance with regulatory requirements.

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 Executive Director is responsible for sustained compliance. The ED/designee will complete audits by reviewing the completed fire drill records monthly for 3 months to ensure all shifts are complete then quarterly for 6 months. The regional team will determine if continued auditing is necessary based on 6 consecutive months of compliance. Monitoring will be on-going.

5. By what date will the systemic changes be completed?

9/22/25

first shift, 2/8/25 second shift, 4/29/25 - third shift, 4/29/25 - second shift, 5/24/25 - first shift, 5/28/25 - second shift, 6/26/25 - third shift, 7/23/25 - first shift, and 8/23/25 - first shift.

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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 SIGNATUREAmy Borzymowski	TITLERegional Director of Operations	(X6) DATE09/19/2025