

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/18/2023
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF BLOOMINGTON MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3203 MOORES PIKE ROAD, BLOOMINGTON, , 47401			
(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: April 17 and 18, 2023 Facility number: 012706 Residential Census: 21 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 19, 2023.	R 0000			
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	1.) The corrective action taken for those residents found to be affected by the deficient practice, is that no specific residents were identified during the survey however all residents, staff and visitors have the potential	05/31/2023	

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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 staff performed at least 12 fire drills every year and at least every 6 months attempted to hold a fire and disaster drill in conjunction with the local fire department. Findings include: On 4/18/23 at 11:25 a.m., the facility's fire drills were reviewed for the past 12 months. A review of the drills indicated fire drills were missing for the months of August, 2022, October, 2022, February, 2023, and March, 2023. There was no	to be affected by this deficient practice. What measures will be put into place or what systemic changes will the facility make to ensure that the noncompliance practice does not recur? Maintenance Supervisor or designee will continue to hold monthly fire drills and to attempt to have the fire department attend fire drills semi-annually. What quality assurance program will be put into place? ED and/or AED to monitor that monthly fire drills are being completed in a timely manner and semi-annual attempts are made to the fire department for their participation in our fire drills. Audits to continue until 100% compliance is achieved. By what date will the systemic changes be completed? ED and/or AED will check monthly for 6 continuing months that the monthly fire drills are taking place starting the month of April, 2023 until September 2023. ED and/or AED will make sure the fire department is contacted for their assistance with the semi annual fire and disaster drill by May 31st, 2023 and again 6 months later to be in compliance.	
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documentation of fire drills being held in conjunction with the local fire department

A review of the Maintenance Director's work history report indicated no fire drills were performed for the months of August, 2022, October, 2022, February, 2023, nor March, 2023.

During an interview on 4/18/23 at 1:30 p.m., the Assistant Executive Director in Training indicated the fire drills were missed and the facility was moving forward.

On 4/18/23 at 2:15 p.m., the Assistant Executive Director in Training provided the facility policy, "Documentation of Drill and Training," undated, and indicated it was the policy currently being used. A review of the policy indicated, "... 1.) If appropriate, try to include your local fire department in each of your fire drills ..." There was no documentation in the policy in regard to how many drills should be conducted each year.

Based on interview and record review, the facility failed to ensure staff performed at least 12 fire drills every year and at least every 6 months attempted to hold a fire and disaster drill in conjunction with the local fire department.

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Findings include:

On 4/18/23 at 11:25 a.m., the facility's fire drills were reviewed for the past 12 months. A review of the drills indicated fire drills were missing for the months of August, 2022, October, 2022, February, 2023, and March, 2023. There was no documentation of fire drills being held in conjunction with the local fire department

A review of the Maintenance Director's work history report indicated no fire drills were performed for the months of August, 2022, October, 2022, February, 2023, nor March, 2023.

During an interview on 4/18/23 at 1:30 p.m., the Assistant Executive Director in Training indicated the fire drills were missed and the facility was moving forward.

On 4/18/23 at 2:15 p.m., the Assistant Executive Director in Training provided the facility policy, Documentation of Drill and Training," undated, and indicated it was the policy currently being used. A review of the policy indicated, "... 1.) If appropriate, try to include your local fire department in each of your fire drills ..." There was no documentation in the policy in regard to how many drills should be conducted each year.

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R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure references were completed for 3 of 5 employees' files reviewed. (Certified Nursing Assistant (CNA) 1, Qualified Medication Aide (QMA) 1, CNA 2) Findings include: On 4/18/23 at 1:30 p.m., the Administrator-In-Training (AIT) presented the employees' files. The employee's file lacked the following: - CNA 1 was hired on 10/24/22. The file lacked any references. - QMA 1 was hired on 11/2/22. The file lacked any references. - CNA 2 was hired on 12/25/22. The file lacked any references. During an interview on 4/18/23 at 2:30 p.m., the AIT indicated	R 0116	1.) The corrective action taken for those residents found to be affected by the deficient practice, is that no specific residents were identified during the survey however all residents, staff and visitors have the potential to be affected by this deficient practice. The facility employment hiring procedure was better defined. The Business Office Manager, ED and/or AED will also verify that references have been completed as part of the new hire paperwork review. The ED and/or AED will in-service leadership staff regarding the reference check policy and procedures. The ED and/or AED will conduct a review of ten employee resident charts for completed references. Review will be conducted once a week for four weeks, monthly for 3 months and quarterly thereafter. Results of these audits will be reviewed by the ED and/or AED, who will establish the threshold of compliance and make further recommendations accordingly.	07/01/2023
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the employees' files lacked references.

On 4/18/23 at 3:02 p.m., the Business Office Manager provided the "New Hire Policy & Procedures," dated 7/30/20 and indicated this was the policy currently being used by the facility. A review of the policy lacked any information on facility requiring references.

Based on interview and record review, the facility failed to ensure references were completed for 3 of 5 employees' files reviewed. (Certified Nursing Assistant (CNA) 1, Qualified Medication Aide (QMA) 1, CNA 2)

Findings include:

On 4/18/23 at 1:30 p.m., the Administrator-In-Training (AIT) presented the employees' files. The employee's file lacked the following:

- CNA 1 was hired on 10/24/22. The file lacked any references.

- QMA 1 was hired on 11/2/22. The file lacked any references.

- CNA 2 was hired on 12/25/22. The file lacked any references.

During an interview on 4/18/23 at 2:30 p.m., the AIT indicated the employees' files lacked references.

These systematic changes will be completed by July 1, 2023.

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	On 4/18/23 at 3:02 p.m., the Business Office Manager provided the "New Hire Policy & Procedures," dated 7/30/20 and indicated this was the policy currently being used by the facility. A review of the policy lacked any information on facility requiring references.			
R 0123	Personnel - Nonconformance 410 IAC 16.2-5-1.4(h)(1-10) (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights.	R 0123	The corrective action taken for those residents found to be affected by the deficient practice, is that no specific residents were identified during the survey however all residents, staff and visitors have the potential to be affected by this deficient practice. New hire Policy and Procedure and new hire check list to be initiated to include Job specific and general orientation and will be monitored by the Business Office Manager at each new hire. The ED and/or AED will also monitor each new hire checklist compliance for 3 months. The systematic changes will be completed 5/31/23.	05/31/2023

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(9) Performance evaluations in accordance with facility policy.

(10) Date and reason for separation.

Based on interview and record review, the facility failed to ensure the specific and general orientation were completed for 3 of 5 employees' files reviewed. (CNA 1, Qualified Medication Aide (QMA) 1, CNA 2)

Findings include:

On 4/18/23 at 1:30 p.m., the Administrator-In-Training (AIT) presented the employees' files. The employee's file lacked the following:

- CNA 1 was hired on 10/24/22. The file lacked the specific and general orientation.

- QMA 1 was hired on 11/2/22. The file lacked the specific and general orientation.

- CNA 2 was hired on 12/25/22. The file lacked the specific and general orientation.

During an interview on 4/18/23 at 2:30 p.m., the AIT indicated the employees' files lacked the specific and general orientation.

On 4/18/23 at 3:02 p.m., the Business Office Manager provided the "New Hire Policy & Procedures," dated 7/30/20 and indicated this was the policy

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currently being used by the facility. A review of the policy indicated..."6. BOM then has them fill out all additional new hire paperwork as outlined in the New Hire Checklist (Indiana)..."

Based on interview and record review, the facility failed to ensure the specific and general orientation were completed for 3 of 5 employees' files reviewed. (CNA 1, Qualified Medication Aide (QMA) 1, CNA 2)

Findings include:

On 4/18/23 at 1:30 p.m., the Administrator-In-Training (AIT) presented the employees' files. The employee's file lacked the following:

- CNA 1 was hired on 10/24/22. The file lacked the specific and general orientation.
- QMA 1 was hired on 11/2/22. The file lacked the specific and general orientation.
- CNA 2 was hired on 12/25/22. The file lacked the specific and general orientation.

During an interview on 4/18/23 at 2:30 p.m., the AIT indicated the employees' files lacked the specific and general orientation.

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	Procedures," dated 7/30/20 and indicated this was the policy currently being used by the facility. A review of the policy indicated..."6. BOM then has them fill out all additional new hire paperwork as outlined in the New Hire Checklist (Indiana)..."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the	R 0217	The corrective action taken for those residents found to be affected by the deficient practice, is that 4 residents were identified during the survey to be affected by this matter. The ED and/or DON will audit 5 ISPs weekly for compliance x 4 weeks, then 3 ISPs weekly x 4 weeks, then 1 ISP weekly x 4 weeks to ensure that the Individual Service Plans are reviewed with resident or designated agent and signed. Audit results will be discussed in monthly AED/DON meetings. The Systematic changes will be complete by 5/31/2023	05/31/2023

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FORM APPROVED

OMB NO. 0938-0391

resident, and a copy of the service plan shall be given to the resident upon request.

(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.

(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.

Based on record review and interview, the facility failed to ensure service plans were signed and dated by the resident or resident's representative for 4 of 7 residents reviewed. (Resident 2, Resident 3, Resident 4, Resident 7)

Findings include:

1. On 4/18/23 at 10:45 a.m., Resident 2's clinical record was reviewed. The resident's diagnosis was dementia.

The resident's Individual Service Plan, dated 11/19/22, was not signed or dated by the resident or the resident's representative.

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2. On 4/18/23 at 11:20 a.m., Resident 3's clinical record was reviewed. The resident's diagnosis was dementia.

The resident's Individual Service Plan, dated 10/31/22, was not signed or dated by the resident or the resident's representative.

3. On 4/18/23 at 11:30 a.m., Resident 4's clinical record was reviewed. The resident's diagnosis was dementia.

The resident's Individual Service Plan, dated 12/1/22, was not signed or dated by the resident or the resident's representative.

4. On 4/18/23 at 11:42 a.m., Resident 7's clinical record was reviewed. The resident's diagnosis was dementia.

The resident's Individual Service Plan, dated 11/16/22, was not signed or dated by the resident or the resident's representative.

On 4/18/23 at 1:35 p.m., the Director of Nursing indicated the Individual Service Plans for Resident 2, Resident 3, Resident 4, and Resident 7 had not been signed or dated by the residents or the residents' representatives, and it was the facility's policy to have the service plans signed and dated by the resident or the resident's representative.

Based on record review and

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interview, the facility failed to ensure service plans were signed and dated by the resident or resident's representative for 4 of 7 residents reviewed. (Resident 2, Resident 3, Resident 4, Resident 7)

Findings include:

1. On 4/18/23 at 10:45 a.m., Resident 2's clinical record was reviewed. The resident's diagnosis was dementia.

The resident's Individual Service Plan, dated 11/19/22, was not signed or dated by the resident or the resident's representative.

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The resident's Individual Service Plan, dated 10/31/22, was not signed or dated by the resident or the resident's representative.

3. On 4/18/23 at 11:30 a.m., Resident 4's clinical record was reviewed. The resident's diagnosis was dementia.

The resident's Individual Service Plan, dated 12/1/22, was not signed or dated by the resident or the resident's representative.

4. On 4/18/23 at 11:42 a.m., Resident 7's clinical record was reviewed. The resident's

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On 4/18/23 at 1:35 p.m., the Director of Nursing indicated the Individual Service Plans for Resident 2, Resident 3, Resident 4, and Resident 7 had not been signed or dated by the residents or the residents' representatives, and it was the facility's policy to have the service plans signed and dated by the resident or the resident's representative.

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