STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK OF BLOOMINGTON MEMORY CARE	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 the Investigation of Complaint IN00393513 and IN00394881. Complaint IN00393513 - Substantiated. No deficiencies cited related to allegations are cited. Complaint IN00394881 - Substantiated. State deficiencies related to the allegations are cited at R0052. Survey date: November 30, 2022 Facility number: 012706 Residential Census: 23 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed December 2, 2022.	R 0000	The Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state regulation.	
R 0052	Residents' Rights - Offense	R 0052	What corrective actions will be	12/16/2022

	410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse for 1 of 3 residents reviewed for abuse. This resulted in the male resident slapping a female resident in the face causing a discolored area to her cheek. (Resident B, Resident C) Finding includes: During an interview on 11/30/22 at 11:35 a.m., QMA 1 (Qualified Medication Aide) indicated she was standing near the nurse's station when she heard Resident C scream. Then, she saw multiple staff run down the hall toward Resident B and Resident C, but she didn't see what happened before the scream. During an interview on 11/30/22 at 12:35 p.m., the DON (Director		accomplished for those residents found to have been affected by the deficient practice? -Resident C was discharged from the facility shortly after the event, the local police department was notified and assisted with his removal with EMS. 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. -The resident assessment will be conducted and reviewed by the DON/ED prior to admission and discuss any diagnosis that may disqualify resident from admission. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? -Continue to in-service staff on 1on1 procedures in the event someone displays behaviors which may harm other residents in the facility. How the corrective actions will be monitored to ensure the deficient practice will not recur? The Executive Director and/or designee will complete weekly	

	of Nursing) indicated Resident B became physically aggressive toward a female resident in the common area. The Dietary Manager stood in front of a female resident when Resident B was swinging a wheelchair pedal around and telling the Dietary Manager to get out of the way. Resident B was redirected by staff toward his room. Then, Resident B hit Resident C in the face while they were in the hallway. Resident C's face was reddened on the left side. The clinical record for Resident C was reviewed on 11/30/22 at 1:27 p.m. The diagnoses included, but were not limited to, mild cognitive dementia. A Mini Mental Exam, dated 11/2/22, indicated Resident C was not cognitively intact. A Progress Note, dated 11/9/22 at 4:23 p.m., indicated Resident C was hit in the face by Resident B in the hall way at this time. Resident B was agitated, and approached Resident C, words were exchanged, and Resident B slapped Resident C in the left side of the face. Resident C stated she is okay, but her face had a red area. The clinical record for Resident B was reviewed on 11/30/22 at 2:09 p.m. The diagnoses		audits on 5 residents for 3 months and then periodically. Any issues identified during the audit will be addressed immediately by the Executive Director and/or the Director of Nursing and will be discussed in the Daily Stand Up meeting Monday through Friday By what date the systemic changes will be completed -12/16/22	

included, but were not limited to, intermittent explosive disorder, depression, and Alzheimer's dementia with behavioral disturbances.

A Mini Mental Exam, dated 11/3/22, indicated Resident B was not cognitively intact.

A Psychiatric Progress Note, dated 10/26/22, indicated Resident B presented to the emergency department for homicidal and suicidal ideations. Resident B threatened to shoot his daughters and hang himself, and according to his daughters, Resident B takes on multiple identities, was wandering in the yard at night, and having conversations with people who were not there.

During an interview on 11/30/22 at 2:35 p.m., QMA 2 indicated Resident B was ramming a wheelchair into the wall in the common area, and he tried to wheel the wheelchair into a female resident, but the Dietary Manager was standing in front of the female resident. The Administrator walked Resident B to his room and then the Administrator came back to the nurse's station area. QMA 2 indicated she saw Resident B come out of his room and yell at Resident C. She wasn't able to hear what Resident B yelled. Resident C turned toward Resident B and said what did

you say to me, and that was when Resident B slapped Resident C on the left side of her face. Then Resident B started to walk down the hall, so she followed him. Once she started following Resident B, he grabbed the fire extinguisher off the wall, and she reached over and slid it out of his hands. Resident B became more agitated and started punching her arm. She yelled help and staff ran down to assist. The Maintenance Director stayed with Resident B until emergency medical staff arrived. By the time ambulance arrived Resident B was back to his normal behavior.

During an interview on 11/30/22 at 2:50 p.m., the Regional Administrator indicated he was the person that walked Resident B to his room after he was swinging the wheelchair pedal. Once Resident B was in his room, he appeared to be calmer. They talked about Resident B's farm and looked at some pictures. Then the Administrator left Resident B's room. Resident B was not with staff. When he heard a scream, he ran down to see what happened. He got Resident B back into his room and the Maintenance Director remained with Resident B until paramedics arrived.

On 11/30/22 at 11:47 a.m., the

Administrator provided a copy of a facility policy, titled Abuse, Neglect and Exploitation Prevention, Prohibition, and Investigation Policy and Procedures, dated 3/14/22, and indicated this was the current policy used by the facility. A review of the policy indicated "Witnessed or Suspected Abuse, Neglect, and Exploitation Procedure: 1. Ensure the safety of the resident and prevent further abuse..."

This State tag relates to Complaint IN00394881.

Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse for 1 of 3 residents reviewed for abuse. This resulted in the male resident slapping a female resident in the face causing a discolored area to her cheek. (Resident B, Resident C)

Finding includes:

During an interview on 11/30/22 at 11:35 a.m., QMA 1 (Qualified Medication Aide) indicated she was standing near the nurse's station when she heard Resident C scream. Then, she saw multiple staff run down the hall toward Resident B and Resident C, but she didn't see what happened before the scream.

During an interview on 11/30/22 at 12:35 p.m., the DON (Director of Nursing) indicated Resident B became physically aggressive toward a female resident in the common area. The Dietary Manager stood in front of a female resident when Resident B was swinging a wheelchair pedal around and telling the Dietary Manager to get out of the way. Resident B was redirected by staff toward his room. Then, Resident B hit Resident C in the face while they were in the hallway. Resident C's face was reddened on the left side.

The clinical record for Resident C was reviewed on 11/30/22 at 1:27 p.m. The diagnoses included, but were not limited to, mild cognitive dementia.

A Mini Mental Exam, dated 11/2/22, indicated Resident C was not cognitively intact.

A Progress Note, dated 11/9/22 at 4:23 p.m., indicated Resident C was hit in the face by Resident B in the hall way at this time. Resident B was agitated, and approached Resident C, words were exchanged, and Resident B slapped Resident C in the left side of the face. Resident C stated she is okay, but her face had a red area.

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	Resident C turned toward Resident B and said what did you say to me, and that was when Resident B slapped Resident C on the left side of her face. Then Resident B started to walk down the hall, so she followed him. Once she started following Resident B, he grabbed the fire extinguisher off the wall, and she reached over and slid it out of his hands. Resident B became more agitated and started punching her arm. She yelled help and staff ran down to assist. The Maintenance Director stayed with Resident B until emergency medical staff arrived. By the time ambulance arrived Resident B was back to his normal behavior.			

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This State tag relates to Complaint IN00394881.

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