STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/02/2022

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 a State Residential Licensure Survey. Survey dates: May 31, June 1, and 2, 2022 Facility number: 012706 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 3, 2022.	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	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? What measures will be put in place or what systemic changes will	07/30/2022

	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 fire and/or disaster drills every 6 months in collaboration with the fire department. Finding includes: On 6/1/22 at 3:00 p.m., a review of the fire dills indicated no collaboration was attempted with the fire department. During an interview on 6/1/22 at 3:10 p.m., the Environmental Services Director indicated the facility had not attempted to include the fire department with		be made to ensure that the deficient practice does not recur? Environmental Service Director will call fire department before drills at least once every six months. How the corrective actions will be monitored to ensure the deficient practice will not recur? To ensure the deficient practice does not recur, the Executive director will verify records of attempts to call the fire department. After 3 months of contact, monitoring will stop if done as expected. No residents directly affected. All residents potentially affected.	

	fire drills. On 6/2/22 at 12:31 p.m., the Executive Director provided the facility policy, "Documentation of Drills and Training," updated 7/15/16, and indicated it was the policy currently being used. A review of the policy did not indicate instruction for staff to collaborate fire drills with the fire department. Based on interview and record review, the facility failed to ensure staff performed fire and/or disaster drills every 6 months in collaboration with the fire department. Finding includes: On 6/1/22 at 3:00 p.m., a review of the fire dills indicated no collaboration was attempted with the fire department. During an interview on 6/1/22 at 3:10 p.m., the Environmental Services Director indicated the facility had not attempted to include the fire department with fire drills.			

	On 6/2/22 at 12:31 p.m., the Executive Director provided the facility policy, "Documentation of Drills and Training," updated 7/15/16, and indicated it was the policy currently being used. A review of the policy did not indicate instruction for staff to collaborate fire drills with the fire department.			
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 staff completed reference checks on new employees for 1 of 1 newly hired employees reviewed. (CNA 1) Finding includes: On 6/2/22 at 10:00 a.m., CNA 1's employee file was reviewed. No reference checks were completed prior to employment. During an interview on 6/2/22 at 11:40 a.m., the Business Office Manager indicated the facility	R 0116	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All employees will have reference checks completed upon hire. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Business office manager will be responsible for reference checks. The Executive Director will check up to 2 new hire employee files a month for the next two months to verify the completion of this measure. How the corrective actions will	07/30/2022

	did not routinely complete background checks on prospective employees and there were no completed reference checks for CNA 1. Based on interview and record review, the facility failed to ensure staff completed reference checks on new employees for 1 of 1 newly hired employees reviewed. (CNA 1) Finding includes: On 6/2/22 at 10:00 a.m., CNA 1's employee file was reviewed. No reference checks were completed prior to employment. During an interview on 6/2/22 at 11:40 a.m., the Business Office Manager indicated the facility did not routinely complete background checks on prospective employees and there were no completed reference checks for CNA 1.		be monitored to ensure the deficient practice will not recur? To ensure compliance, the Executive Director will conduct random audits weekly to ensure reference checks have been completed. After one month of compliance monitoring will be ended and monthly random audits will be conducted. No residents directly affected. All residents potentially affected.	
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A	R 0117	What corrective actions will be accomplished for those residents found to have been affected by the deficient practices? This facility will ensure a minimum of one employee on each shift has a current First Aid and CPR certification.	07/30/2022

	minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a minimum of 1 employee with a current First Aid (FA) and Cardiopulmonary Resuscitation (CPR) certification was on the facility site for each shift for 7 of the 7 days reviewed. Finding includes: On 6/1/22 at 2:40 P.M., the DON (Director of Nursing) provided the schedule for the week of 5/22/22-5/28/22 and copies of FA and CPR certification cards for employees on the schedule for the week reviewed. A review of the nurses' and		What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? Our facility will hold ongoing FA & CPR courses. All employee licenses and certifications will be verified. Community will maintain copies of training and certifications in the employee file and ensure that at least one staff member is working who is both CPR and First Aid certified. How the corrective actions will be monitored to ensure the deficient practice will not recur? The community will ensure every shift has FA and CPR certified staffing. After 2 weeks of compliance. Staffing will be audited weekly to ensure FA and CPR certified staffing is ongoing. The Executive Director will conduct ongoing random audits of employee CPR and First Aid certification to ensure requirement of minimum staff on site is met. No residents directly affected. All residents potentially affected.	

	certified nursing assistants' schedule, dated 5/22/21-5/28/28, indicated there were no staff members on site who were FA and CPR certified for the following dates and shifts: 5/22/22 third shift 5/23/22 third shift 5/24/22 first, second, and third shift 5/25/22 second and third shift 5/26/22 third shift 5/27/22 third shift 5/28/22 third shift On 6/2/22 at 12:35 P.M., the DON indicated the facility did not have a CPR or FA certified staff member for all shifts. The DON further indicated the facility follows the state regulations related to CPR and FA certified staff members. Based on record review and interview, the facility failed to ensure a minimum of 1 employee with a current First Aid (FA) and Cardiopulmonary Resuscitation (CPR) certification was on the facility site for each shift for 7 of the 7 days reviewed. Finding includes:			

	On 6/1/22 at 2:40 P.M., the DON (Director of Nursing) provided the schedule for the week of 5/22/22-5/28/22 and copies of FA and CPR certification cards for employees on the schedule for the week reviewed. A review of the nurses' and certified nursing assistants' schedule, dated 5/22/21-5/28/28, indicated there were no staff members on site who were FA and CPR certified for the following dates and shifts: 5/22/22 third shift 5/23/22 third shift 5/24/22 first, second, and third shift 5/25/22 second and third shift 5/26/22 third shift 5/27/22 third shift 5/28/22 third shift On 6/2/22 at 12:35 P.M., the DON indicated the facility did not have a CPR or FA certified staff member for all shifts. The DON further indicated the facility follows the state regulations related to CPR and FA certified staff members.			

R 0273	Food and Nutritional Services - Deficiency 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 staff wore a hair coverings while in the kitchen preparing food for 2 of 2 kitchen observations. (Employee 1, Employee 2, Employee 3) Findings include: On 6/1/22 at 9:40 A.M., Employee 1 was observed preparing food in the kitchen with no hair covering on her head. On 6/1/22 at 9:45 A.M., a sign at the entrance to the kitchen was observed to state, "Do not enter kitchen without a hairnet". On 6/2/22 at 10:30 A.M. and 11:05 A.M., Employee 1 and Employee 2 were observed preparing food in the kitchen with no hair coverings on their heads. On 6/2/22 at 11:55 A.M., Employee 1, Employee 2, and Employee 3 were observed in	R 0273	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Facility will ensure all staff wear a hair covering while in the kitchen preparing food. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? All staff in-service to be conducted regarding hair covering. How the corrective actions will be monitored to ensure the deficient practice will not recur? Kitchen will be audited daily for compliance. After2 weeks of compliance, Managers are to periodically review compliance during daily rounds. No residents directly affected. All residents potentially affected.	07/15/2022

the kitchen standing over prepared food with no hair coverings on their heads.

During an interview on 6/2/22 at 12:35 P.M., the Executive Director indicated staff were to wear hair coverings while in the kitchen.

On 6/2/22 at 12:35 P.M., the Executive Director provided the Code of Dress and Personal Appearance Policy & Procedures and indicated this was the policy currently used by the facility. A review of the policy indicated, "...the following practices will be enforced by the Dining Services Manger...hairnets, hair restraints shall be worn..."

On 6/2/22 at 12:35 P.M., a review of the "Retail Food Establishment Sanitation Requirement Manual: 410 IAC 7-24-138, dated November 13, 2004, indicated, "....food employees shall wear hair restraints..."

Based on observation, interview, and record review, the facility failed to ensure staff wore a hair coverings while in the kitchen preparing food for 2 of 2 kitchen observations. (Employee 1, Employee 2, Employee 3)

Findings include:

On 6/1/22 at 9:40 A.M.,

Employee 1 was observed preparing food in the kitchen with no hair covering on her head.

On 6/1/22 at 9:45 A.M., a sign at the entrance to the kitchen was observed to state, "Do not enter kitchen without a hairnet".

On 6/2/22 at 10:30 A.M. and 11:05 A.M., Employee 1 and Employee 2 were observed preparing food in the kitchen with no hair coverings on their heads.

On 6/2/22 at 11:55 A.M., Employee 1, Employee 2, and Employee 3 were observed in the kitchen standing over prepared food with no hair coverings on their heads.

During an interview on 6/2/22 at 12:35 P.M., the Executive Director indicated staff were to wear hair coverings while in the kitchen.

On 6/2/22 at 12:35 P.M., the Executive Director provided the Code of Dress and Personal Appearance Policy & Procedures and indicated this was the policy currently used by the facility. A review of the policy indicated, "...the following practices will be enforced by the Dining Services Manger...hairnets, hair restraints shall be worn..."

On 6/2/22 at 12:35 P.M., a

	review of the "Retail Food Establishment Sanitation Requirement Manual: 410 IAC 7-24-138, dated November 13, 2004, indicated, "....food employees shall wear hair restraints..."			

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