STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155796	A. BUILDING 00 B. WING	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARS THE	14409 SUNRISE CT LEO, IN 46765

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 9, 10, 11, 12 and 13, 2024 Facility number: 001215 Provider number: 155796 AIM number: 100450890 Census Bed Type: SNF/NF: 39 Residential: 7 Total: 46 Census Payor Type: Medicare: 2 Medicaid: 21 Private: 23 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 16, 2024	F 0000	We respectfully request consideration for paper compliance. If you have any questions or concerns, please contact Amanda Duggan, HFA at 260-627-2191. Thank you and have a great day! Amanda Duggan, HFA	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure the resident was provided with required transfer information for a hospital transfer for 1 of 2 residents reviewed (Resident 37).	F 0623	All residents have the right to have notice requirements before transfer/discharge. This requirement was not met by one of two residents reviewed. All residents have the potential to be affected by this requirement not	10/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda M Duggan	Health Facility Administrator	10/01/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Findings include: Resident 37's record was reviewed on 9/11/24 at 2:28 PM. Diagnoses included dementia, cognitive communication deficit, gastrointestinal hemorrhage and anemia. Resident 37's Quarterly Minimum Data Set (MDS), dated 6/28/24, indicated the resident's Brief Interview for Mental Status (BIMS) was 6 (severe cognitive impairment). The MDS indicated Resident 37 was being administered anticoagulants (blood thinners). A Health Status Note, dated 5/31/24 at 12:10 AM, indicated Resident 37 had been transferred to the hospital by an ambulance due to critical laboratory results. An Admission Summary, dated 6/3/24 at 11:33 PM, indicated Resident 37 had returned from the hospital at 3:00 PM. A hopsital transfer form was unable to be located in the resident's record for the date of 5/31/24. In an interview, on 9/13/24 at 10:10 AM, Licensed Practical Nurse (LPN) 27 indicated a transfer form should be used each time a resident was sent to the hospital. LPN 27 indicated a copy of the transfer form should be sent with the resident to the hospital. LPN 27 indicated the original transfer form should be placed in the resident's medical record. In an interview, on 9/13/24 at 1:39 PM, the Administrator indicated a hospital transfer form for Resident 37 should have been included in the resident's record but had not been completed by the nursing staff.		being met. All transfers or discharges out will be reviewed within 24 business hours of transfer out. During review staff will make sure that the eInteract Transfer Form assessment, eInteract Change of Condition evaluation, as well as Progress Note completed in regards to the reason for the transfer or discharge. Nurses will be educated on the requirements before transfer/discharge. (Attachment D) Audits will be completed 3x a week for a month and then monthly until 90% compliance is met for 6 months. Results will be reviewed at time of audit and then monthly with the QAPI meetings. (Attachment C)	

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	In an interview, on 9/13/24 at 11:40 AM, the Director of Nursing indicated they were unable to locate a facility hospital transfer policy. 3.1-12(a)(6)(A)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure physician orders related to a high-risk medication were clarified and followed for 1 of 2 residents reviewed (Resident 37). Findings include: Resident 37's record was reviewed on 9/11/24 at 2:28 PM. Diagnoses included dementia, cognitive communication deficit, gastrointestinal hemorrhage and anemia. Resident 37's Quarterly Minimum Data Set (MDS) dated 6/28/24 indicated the resident's Brief Interview for Mental Status (BIMS) was 6 (severe cognitive impairment). The MDS indicated Resident 37 was being administered Eliquis (blood thinner). An Order Note, dated 5/21/24 at 12:13 PM, indicated Resident 37 had a moderate amount of rectal bleeding. New orders were obtained from the Nurse Practitioner (NP). The new orders and labs were noted into the facility laboratory (lab) system and Resident 37's medical record. A physician order, dated 5/21/24, indicated Resident 37 was to have blood tests drawn for a complete blood count (counts the different blood	F 0684	All residents have the right to have Quality of Care. This requirement was not met by one of two residents reviewed. All residents have the potential to be affected by this requirement not being met. All physician orders are to be reviewed/ clarified and followed as written. All physician orders will be reviewed within 24 hours of being ordered. During review DON or designee will review all orders for accuracy and verify they have been entered into PCC correctly and completed if applicable. (Attachment E) Audits will be completed 3x a week for a month and then monthly until 90% compliance is met for 6 months. Results will be reviewed at time of audit and then monthly with the QAPI meetings. (Attachment C)	10/01/2024

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	cells and hemoglobin (iron) also known as a CBC) and a comprehensive metabolic panel (measures kidney and liver function also known as a CMP) on the next lab day. The physician order indicated a CBC and CMP were to be collected on the next lab day 1 time a day for a positive stool blood test until 5/23/24 at 11:59 PM. A physician order, dated 5/23/24, indicated Resident 37 was to have blood tests drawn for a CBC and a basic metabolic panel (measures kidney function also known as a BMP) on 5/26/24 for gastrointestinal bleeding (GI bleed) for 1 day. A lab report, dated 5/23/24, indicated Resident 37's red blood cell count was 2.68 (normal range is 3.9 to 5.4) and their hemoglobin level was 7.5 (normal range is 12 to 16). A physician order dated 5/24/24 indicated Resident 37's Eliquis was to be held until 5/28/24 and the resident was to be referred for an outpatient blood transfusion. An Order Note, dated 5/24/24 at 9:24 AM, indicated Resident 37's lab results were reviewed by the NP. New orders were received and noted. An Order Note, dated 5/25/24 at 9:49 PM, indicated Resident 37 fell from their wheelchair and had bleeding from their head. Resident 37 was sent to the emergency department due to the resident's high risk for bleeding. An Order Note, dated 5/27/24 at 3:25 AM, indicated a lab technician was at the facility to draw Resident 37's blood for a CMP and a BMP. An Order Note, dated 5/27/24 at 1:07 PM, indicated Resident 37 had a bowel movement that			

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	was positive for blood. A lab report, dated 5/27/24, indicated Resident 37's CMP levels were in normal range for the resident. The lab report did not included the CBC results ordered fo 5/26/24. An Order Note, dated 5/28/24 at 12:03 PM indicated the NP was notified of Resident 37's lab results. An Order Note, dated 5/30/24 at 6:38 AM, indicated the physician ordered a CBC in 2 weeks on 6/13/24. A NP Medical Visit note, dated 5/30/24, at 11:51 AM indicated Resident 37's previous blood tests had not been completed as ordered. The NP indicated a STAT (immediate) CBC was to be collected. The NP indicated the STAT CBC order had been discussed with the nursing staff. An Order Note, dated 5/30/24 at 12:46 PM, indicated the NP reviewed Resident 37's CBC results from 5/27/24. An Order Note, dated 5/30/24 at 6:57 PM, indicated the NP ordered outpatient infusion services for Resident 37. Resident 37's Medication Administration Record, dated 5/1/24 through 5/31/24, indicated the resident was to be administered a Eliquis 2 times a day. The MAR indicated the Eliquis had not been administered from 5/24/24 at 4:30 PM through 5/27/24. The Eliquis was resumed on 5/28/24. Resident 37 was administered the Eliquis 2 times a day on 5/28/24, 5/29/24 and 5/30/24. A Health Status Note, dated 5/30/24 at 11:45 PM,			

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	indicated Resident 37 had a critical hemoglobin level of 4.6. A Health Status Note, dated 5/31/24 at 12:10 AM, indicated Resident 37 had been transferred to the hospital by an ambulance due to critical laboratory results. An Admission Summary, dated 6/3/24 at 11:33 PM, indicated Resident 37 had returned from the hospital at 3:00 PM. A hospital discharge summary, dated 6/3/24, indicated Resident 37 was admitted to the hospital on 5/31/24 with a hemoglobin level of 4.6. Resident 37's hemoglobin level of 5.4 was labeled as a panic result on 5/31/24 at 1:37 AM. In an interview on 9/13/24 at 10:10 AM, Licensed Practical Nurse (LPN) 27 indicated blood thinners should not be given if a GI bleed was suspected or known. LPN 27 indicated a blood thinner that was ordered to be held should not have been resumed until repeat CBC results were known. LPN 27 indicated in the event of a missed CBC; the physician should have been made aware of the missed blood test and to clarify when the blood thinner was to be resumed. In an interview on 9/13/24 at 11:40 AM, the Director of Nursing indicated they were unable to locate a facility policy related to care for a GI bleed. The Facility Assessment, dated 9/4/24, indicated the facility could care for residents who were diagnosed with anemia, residents diagnosed with gastroesophageal reflux (GERD) and residents who were at risk for bleeding.			

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	The National Institute of Health (NIH.gov, 2022) indicated a hemoglobin level below 7 requires a blood transfusion 3.1-37			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, interview, and record review the facility failed to ensure hand hygiene was performed during wound care for 1 of 2 residents reviewed (Resident 12). Findings include: During wound care observation, on 9/11/24 at 10:29 AM, Licensed Practical Nurse (LPN) 5 entered Resident 12's room where a tray of supplies was prepared on the bedside table containing a pair of scissors, dressing supplies, wound cleanser, and Dakins solution. LPN 5 opened the Dakins solution and poured about 10 ml in a plastic cup. She then opened a jar of wound packing, pulled out about 1 inch of packing, cut it with the scissors, and placed the packing in the cup of solution. She poured wound cleanser in another cup and placed a piece of gauze in the cup. LPN 5 removed the dressing and packing for Resident 12's right hip wound and then picked up a prepared plastic cup containing the wound cleanser and cleaned the wound with the gauze, then patted it dry with a dry piece of gauze. No hand hygiene or glove change was observed. LPN 5 picked up the cup of Dakin's solution and had the soaked packing in her hand, beginning to turn her body toward Resident 12 when the activity was stopped.	F 0686	All residents have the right to Treatment/Svcs to Prevent/Heal Pressure Ulcer. This requirement was not met by one of two residents reviewed. All residents with Treatment/Svcs to Prevent/Heal Pressure Ulcer have the potential to be affected by this requirement not being met. All nurses providing this care will be in serviced on proper procedure for Dressing a Wound as well as Hand Hygiene. Skills check offs will be performed to show proper procedure is followed. (Attachment F) Audits will be completed 3x a week for a month and then monthly until 90% compliance is met for 6 months. Results will be reviewed at time of audit and then monthly with the QAPI meetings. (Attachment C)	10/01/2024

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	During an interview on 9/11/24 at 10:35 AM, LPN 5 indicated she should have washed her hands and changed gloves before handling the clean dressing materials. She indicated she was not sure about how often hand hygiene and glove changes should be performed in the wound care process. She also indicated she did not know she should clean the scissors prior to use with wound care products. Resident 12's record was reviewed on 9/11/24 at 12:16 PM. Diagnoses included multiple sclerosis, type 2 diabetes without complications, and dermatitis, unspecified. Resident 12's current quarterly Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). The MDS indicated the resident had a stage 4 pressure ulcer. Resident 12's current care plan titled Wound, I have developed an actual pressure injury, indicated the resident had a problem of a stage 4 pressure ulcer on her right buttock, with a goal date of 10/30/24. Interventions included Dakins solution treatment should be administered as ordered. Physician orders dated 8/29/24 indicated Resident 12's right buttock should be washed with baby soap and water and patted dry. A Dakin's solution saturated, one inch packing strip should be packed tightly to the wound, covered with an abdominal pad, kerlix and tape, two times daily. In an interview on 9/11/24 at 12:10 PM, the Director of Nursing indicated LPN 5 should have washed her hands and applied her gloves prior to the procedure, after removing the old dressing,			

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	after cleaning the wound and any other time her gloved hands contacted contaminated items. A current policy, dated 2017, titled Dressing a Wound, indicated hand hygiene and applying new gloves should be performed before and after removing a dressing, before and after cleansing the wound, before applying the new dressing, and after the completion of the procedure. 3.1-40			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review the facility failed to ensure respiratory care was provided according to physician's orders for 1 of 2 residents reviewed (Resident 29). Findings include: During an observation and interview, on 9/9/24 at 10:41 AM, Resident 29 was observed lying in bed with an oxygen concentrator positioned near the bed with tubing and a nasal cannula lying on top of the concentrator. The nasal cannula was not contained in a bag. The Director of Nursing (DON) indicated oxygen tubing not in use should be bagged to prevent contamination. During an observation, on 9/10/24 at 10:17 AM, Resident 19's oxygen concentrator was observed positioned near the bed with tubing and a nasal cannula lying on top of the concentrator. The nasal cannula was not contained in a bag. Resident 29's record was reviewed on 9/9/24 at 1:30 PM. Diagnoses included Alzheimer's disease	F 0695	All residents have the right to Respiratory/Tracheostomy Care and Suctioning. This requirement was not met by one of two residents reviewed. All residents with Respiratory/Tracheostomy Care and Suctioning have the potential to be affected by this requirement not being met. All nurses providing this care will be in serviced Oxygen and Nebulizer Monitoring Review as well as Oxygen Administration. (Attachment G) Audits will be completed 3x a week for a month and then monthly until 90% compliance is met for 6 months. Results will be reviewed at time of audit and then monthly with the QAPI meetings. (Attachment C)	10/01/2024

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with early onset, dyspnea, unspecified and heart failure unspecified.

Resident 29's current significant change Minimum Data Set (MDS) dated 7/10/24 indicated a Basic Interview for Mental Status (BIMS) should not be done because the resident was rarely or never able to make herself understood. The MDS indicated Resident 29 used supplemental oxygen and did not have recorded occurrences of care refusal.

Resident 29's current care plan titled, has shortness of breath, indicated Resident 29 had a problem of dyspnea, with a goal date of 10/10/24. Interventions included to administer oxygen as ordered.

Physician orders dated 5/24/23 indicated oxygen should be administered at a rate of 2 liters per minute while lying in bed every shift.

Progress notes dated 9/9/24 and 9/10/24 did not indicate any care refusals had occurred.

In an interview on 9/11/24 at 9:41 AM, LPN 5 indicated oxygen should be in place at 2 liters per minute for Resident 29 when lying in bed, at bedtime, and for naps. She indicated the tubing should be contained in a plastic bag when not in use.

A current policy titled Oxygen Administration dated 9/10/24 provided by the Administrator indicated oxygen should be administered according to physician's orders.

3.1-47(a)(6)

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F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review the facility failed to ensure food items were laebled and stored to prevent contamination and hand hygiene was performed consistently. 39 of 39 residents residing in the facility were served food prepared in the kitchen. Findings include: During an observation and interview on 9/9/24 at 9:16 AM, a container of chopped lettuce was observed in an assembly area with no date on the container. The lettuce was observed to have brown and yellow edges. Cook 2 indicated the lettuce appeared old and should not be used. A container of grape tomatoes was observed in the assembly area with no date on the container. A package of polish sausage was wrapped in foil in the freezer with no date found on the package. Bags containing corn, peas and potatoes were also found open with the packaging twisted and tied with a twist-tie in the walk-in freezer with no open dates. Cook 2 indicated items should be labeled and dated when opened. A package was observed in the walk-in cooler labeled "turkey 9/1-9/7". Cook 2 indicated the turkey was expired and should have been thrown away 2 days ago. In the reach in freezer, a large container of Denali caribou ice cream did not have an open date. In the reach in cooler, a bag of shredded cheddar cheese, a bag of parmesan cheese and a bag of whipped topping were open, with the packaging twisted and closed with a twist tie. No dates were found on the packages. In the reach in drink cooler, an open container of iced tea concentrate had an open date of 7/24. Cook 2 indicated he did	F 0812	All residents have the right to have their food prepared and maintained with proper kitchen sanitation. This requirement was not met for 39 of 39 residents. All residents have the potential to be affected by this deficient practice. Dietary staff will be reeducated on label and dating items as well as proper hand hygiene. Administrator and or Designee will reeducate staff on hand hygiene as well as the need to label and date all food items. (Attachment A) This will be completed initially and then spot-checked Monday, Wednesday and Friday for 30 days and then there after monthly. (Attachment B) Audits will be completed 3x a week for a month and then monthly until 90% compliance is met for 6 months. Results will be reviewed at time of audit and then monthly with the QAPI meetings. (Attachment C)	10/01/2024

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	not know if he should use it or not. During an observation, on 9/9/24 at 9:24 AM, Dietary aide 4 was observed returning to the kitchen from the dining area and preparing to perform dishwashing duties. She washed her hands for 7 seconds, then went to the dishwashing station to perform her duties. During an observation, on 9/9/24 at 11:45 AM, Cook 2 began the process of pureeing meat for the lunch meal. Cook 2 indicated he needed to obtain water to complete the process, exited the kitchen and went to the dining area to obtain the water. No hand hygiene was performed. During an interview, on 9/10/24 at 10:54 AM, the Dietary Manager indicated hands should be washed with soap and good friction for at least 20 seconds and hands should be washed when changing tasks and work areas and after touching a resident. She indicated the cook should have washed his hands before returning to his workstation to finish the puree process. She indicated hand hygiene should be performed when changing workstations and after touching a resident or their belongings. She indicated all food should be labeled and dated when opened. In an interview on 9/13/24 at 12:03 PM the Administrator indicated all residents in the facility were served food consumed in the kitchen. A current policy, dated 2/22/21, titled Safe Food Storage Guidelines provided by the Administrator on 9/11/24 at 8:25 AM indicated all products should be used by expiration date or discarded. A current policy, dated 9/10/24, titled Infection Control Handwashing provided by the			

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	Administrator on 9/11/24 at 8:25 AM indicated hand hygiene should be performed before and after handling food, after contact with the resident environment, and before and after assisting a resident with meals. A current policy, undated, titled Handwashing/Handrub indicated staff should rub hands together vigorously for at least 20 seconds during handwashing. 3.1-21(i)3			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: September 9, 10, 11, 12 and 13, 2024 Facility number: 001215 Residential Census: 7 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality reivew completed September 16, 2024.	R 0000	We respectfully request consideration for paper compliance. If you have any questions or concerns, please contact Amanda Duggan, HFA at 260-627-2191. Thank you and have a great day! Amanda Duggan, HFA	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review the facility failed to ensure food items were laebled and stored to prevent contamination and hand hygiene was performed consistently. 7 of 7 residents residing in the facility were served food	R 0273	All residents have the right to have their food prepared and maintained with proper kitchen sanitation. This requirement was not met for 7 of 7 residents. All residents have	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155796	A. BUILDING 00 B. WING	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARS THE	14409 SUNRISE CT LEO, IN 46765

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	prepared in the kitchen. Findings include: During an observation and interview on 9/9/24 at 9:16 AM, a container of chopped lettuce was observed in an assembly area with no date on the container. The lettuce was observed to have brown and yellow edges. Cook 2 indicated the lettuce appeared old and should not be used. A container of grape tomatoes was observed in the assembly area with no date on the container. A package of polish sausage was wrapped in foil in the freezer with no date found on the package. Bags containing corn, peas and potatoes were also found open with the packaging twisted and tied with a twist-tie in the walk-in freezer with no open dates. Cook 2 indicated items should be labeled and dated when opened. A package was observed in the walk-in cooler labeled "turkey 9/1-9/7". Cook 2 indicated the turkey was expired and should have been thrown away 2 days ago. In the reach in freezer, a large container of Denali caribou ice cream did not have an open date. In the reach in cooler, a bag of shredded cheddar cheese, a bag of parmesan cheese and a bag of whipped topping were open, with the packaging twisted and closed with a twist tie. No dates were found on the packages. In the reach in drink cooler, an open container of iced tea concentrate had an open date of 7/24. Cook 2 indicated he did not know if he should use it or not. During an observation, on 9/9/24 at 9:24 AM, Dietary aide 4 was observed returning to the kitchen from the dining area and preparing to perform dishwashing duties. She washed her hands for 7 seconds, then went to the dishwashing station to perform her duties.		the potential to be affected by this deficient practice. Dietary staff will be reeducated on label and dating items as well as proper hand hygiene. Administrator and or Designee will reeducate staff on hand hygiene as well as the need to label and date all food items. (Attachment A) This will be completed initially and then spot-checked Monday, Wednesday and Friday for 30 days and then there after monthly. (Attachment B) Audits will be completed 3x a week for a month and then monthly until 90% compliance is met for 6 months. Results will be reviewed at time of audit and then monthly with the QAPI meetings. (Attachment C)	

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	During an observation, on 9/9/24 at 11:45 AM, Cook 2 began the process of pureeing meat for the lunch meal. Cook 2 indicated he needed to obtain water to complete the process, exited the kitchen and went to the dining area to obtain the water. No hand hygiene was performed. During an interview, on 9/10/24 at 10:54 AM, the Dietary Manager indicated hands should be washed with soap and good friction for at least 20 seconds and hands should be washed when changing tasks and work areas and after touching a resident. She indicated the cook should have washed his hands before returning to his workstation to finish the puree process. She indicated hand hygiene should be performed when changing workstations and after touching a resident or their belongings. She indicated all food should be labeled and dated when opened. In an interview on 9/13/24 at 12:03 PM the Administrator indicated all residents in the facility were served food consumed in the kitchen. A current policy, dated 2/22/21, titled Safe Food Storage Guidelines provided by the Administrator on 9/11/24 at 8:25 AM indicated all products should be used by expiration date or discarded. A current policy, dated 9/10/24, titled Infection Control Handwashing provided by the Administrator on 9/11/24 at 8:25 AM indicated hand hygiene should be performed before and after handling food, after contact with the resident environment, and before and after assisting a resident with meals. A current policy, undated, titled Handwashing/Handrub indicated staff should rub hands together vigorously for at least 20 seconds			

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	during handwashing.			