STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155822	A. BUILDING 00 B. WING	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDAR CREEK HEALTH CAMPUS	18275 BURR STREET LOWELL, IN 46356

(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 the Investigation of Nursing Home and Residential Complaints IN00417117 and IN00420281 and Nursing Home Complaint IN00424116. Complaint IN00417117 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00420281 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00424116 - Federal/state deficiencies related to the allegations are cited at F677 and F694. Survey dates: January 2, 3, and 4, 2024 Facility number: 013144 Provider number: 155822 AIM number: 201246060 Census Bed Type: SNF/NF: 31 SNF: 22 Residential: 30 Total: 83 Census Payor Type: Medicare: 11 Medicaid: 24 Other: 18 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/9/24.	F 0000	The submission of this plan of correction does not indicate an admission by Cedar Creek Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Cedar Creek Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelly Dyek	Executive Director	01/19/2024

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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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure residents who required extensive and dependent care for activities of daily living (ADL's) received showers/bathing at least twice weekly for 3 of 3 residents reviewed for ADL's. (Residents B, C, and D) Findings include: 1. During an interview on 1/2/24 at 6:58 p.m., Resident B indicated she usually received showers, though sometimes did not get a shower and sometimes received a bed bath instead of a shower. Resident B's record was reviewed on 1/3/24 at 12:52 p.m. The diagnoses included, but were not limited to, Parkinson's disease and dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 12/13/23, indicated a moderately impaired cognitive status, no behaviors, and was dependent for showers/bathing. An ADL Care Plan, dated 10/19/21, indicated assistance would be given by staff for all ADL's. The resident's shower schedule indicated showers were to be received on Wednesday and Saturday evenings. The Plan of Care for Bathing indicated in October	F 0677	1. Shower/bathing preferences have been completed on all residents. All residents have the potential to be affected by the alleged deficient practice. 2. Nursing staff educated on bathing preferences. 3. As a measure of ongoing compliance, the DHS and/or designee will audit bathing preferences to ensure showers/baths are being completed on 5 residents 3 times a week x4 weeks, weekly x4 weeks, then every other week x4 weeks, and monthly x3. 4. As a quality measure, the DHS and/or designee will review any findings and corrective action at least quarterly in the campus quality assurance meeting. The plan will be revised as warranted.	01/22/2024

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	of 2023, showers had not been completed on October 11, 14, and 21, 2023. Showers had not not been completed on November 4 and 11, 2023 and a bed bath was given on November 29, 2023. Showers had not been completed on December 2, 6, 9, 16, 27, 30, 2023 and a bed bath had been given on December 19, 2023. During an interview on 1/3/24 at 10:16 a.m., the Director of Nursing indicated she had just received a concern from the resident that she had received a bed bath instead of a shower and was informed the CNA had told her she could not have a shower. 2. Resident C's closed record was reviewed on 1/2/23 at 6:05 p.m. The diagnoses included, but were not limited to, stroke. An Admission MDS assessment, dated 6/1/23, indicated an intact cognitive status, no behaviors, and required extensive assistance with bathing. An ADL Care Plan, dated 6/26/23, indicated assistance was required for all ADL's. The resident census indicated an admission date of 5/26/23 and a discharge to an acute care hospital on 6/6/23. The resident received two showers from Friday 5/26/23 to Tuesday 6/6/23, on Sunday 5/28/23 and Friday 6/2/23. During an interview on 1/3/24 at 12 p.m., the Director of Nursing indicated the staff needed to work on ensuring showers were completed. 3. Resident D was interviewed on 1/2/24 at 5:13 p.m. and indicated she currently usually received baths as scheduled.			

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	Resident D's record was reviewed on 1/3/24 at 2:33 p.m. The diagnoses included, but were not limited to, stroke. A Quarterly MDS assessment, dated 12/27/23, indicated an intact cognitive status, no behaviors, and was dependent for bathing/showers. An ADL Care Plan, dated 8/29/22, indicated assistance was needed for all ADL's. The resident was scheduled for showers on Tuesday and Friday evenings. The Plan of Care for bathing indicated bathing/shower had not been completed on October 3, 6, 17, 20, and 27, 2023, November 10, 14, and 21, 2023, and December 8, 2023. This citation relates to Complaints IN00417117, IN00420281, and IN00424116. 3.1-38(a)(2)(A)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and interview, the facility failed to care for and obtain Physician's Orders to care for a PICC (peripherally inserted central catheter) line and an implanted venous port (intravenous line (IV) that is inside the body with a tube attached to the port)(PAC) in	F 0694	1. All residents with PICC and port a cath access have the potential to be affected by the alleged deficient practice. Audits completed on all residents who have a PICC or port a cath access.	01/22/2024

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	accordance with professional standards of practice, related to dressing changes for 1 of 2 residents reviewed for PICC line/port care. (Residents C and F) Findings include: 1. Resident C's closed record was reviewed on 1/2/23 at 6:05 p.m. The diagnoses included, but were not limited to, stroke. A Re-Admission Minimum Data Set (MDS) assessment, dated 6/29/23, indicated a moderately impaired cognitive status and no IV medications ordered at the facility. A Care Plan, dated 6/26/23, indicated a PAC was present. The site care was to be completed as ordered. A Nurse's Admission Progress Note, dated 6/26/23 at 2:33 p.m., indicated a PAC was present on in the right chest area and was flushed without difficulties. The dressing on the PAC was 6/22/23. There were no Physician's Orders obtained for flushing and dressing coverage for the PAC. The Medication and Treatment Administration Records (MAR and TARs) and the Nurses' Progress Notes had not indicated the POC had any further flushes completed or that a dressing change had been completed. During an interview on 1/3/24 at 2:53 p.m., the Director of Nursing (DON), indicated there had been no Physician's Orders obtained for the care of the PAC and no dressing changes had been completed.		2. Nurses educated on PICC and port a cath care. 3. As a measure of ongoing compliance, the DHS and/or designee will audit charts for PICC and/or port a cath 3 times a week x4 weeks, weekly x4 weeks, every other week x4 weeks, and monthly x3. 4. As a quality measure, the DHS and/or designee will review any findings and corrective action at least quarterly in the campus quality assurance meetings. The plan will be revised as warranted.	

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	2. Resident F was observed on 1/2/24 at 6:17 p.m. There was a PICC line with a dressing, dated 12/29/23, located on the right upper extremity. Resident F's record was reviewed on 1/3/24 at 3:46 p.m. The diagnoses included, but were not limited to, colon cancer. An Admission MDS assessment, dated 12/15/23, indicated an intact cognitive status, received IV medications with an IV access. A Physician's Order, dated 12/14/23, indicated the dressing which covered the PICC line insertion was to be changed every five days. The Admission Nurse's Progress Note, dated 12/9/23 at 4:32 p.m., indicated a PICC line was present on the right upper extremity and the dressing over the PICC was clean, dry and intact. There was no documentation that indicated the dressing had been changed on 12/9/23. The MAR/TARs, dated 12/2023, indicated the dressing change had not been completed on 12/14/23. The documentation indicated they were waiting on Physician's Orders to discontinue the PICC line since the IV antibiotic had been completed. The first dressing change to the PICC line was completed on 12/19/23. An Infusion Maintenance Table, dated 5/2016 and received from the DON as current for care procedures for IV lines, indicated the dressings for the PAC and the PICC were to be completed on admission, every 5-7 days, and as needed. The gauze dressing was to be changed every 48 hours. Gauze dressings were only used if there was an allergy or problem with the transparent dressing.			

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R 0000 Bldg. 00	This citation relates to Complaint IN00424116. 3.1-47(a)(2) This visit was for the Investigation of Nursing Home and Residential Complaints IN00417117 and IN00420281. This visit included the Investigation of Nursing Home Complaint IN00424116. Complaint IN00417117 - No deficiencies related to the allegations are cited. Complaint IN00420281 - No deficiencies related to the allegations are cited. Complaint IN00424116 - Federal/state deficiencies related to the allegations are cited at F677 and F694. Survey dates: January 2, 3, and 4, 2024 Facility number: 013144 Residential Census: 30 Cedar Creek Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaints IN00417117 and IN00420281. Quality review completed on 1/9/24.	R 0000	The submission of this plan of correction does not indicate an admission by Cedar Creek Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Cedar Creek Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	