| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155796 | A. BUILDING 00<br>B. WING | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CEDARS THE | 14409 SUNRISE CT<br>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<br><br>Bldg. 00 | This visit was for the Investigation of Nursing Home Complaint IN00413820. This visit included the Investigation of Residential Complaint IN00413976.<br><br>Complaint IN00413820 - Federal/State deficiencies related to the allegations are cited at F744.<br><br>Survey date: August 8 and 9, 2023<br><br>Facility number: 001215<br>Provider number: 155796<br>AIM number: 100450890<br><br>Census Bed Type:<br>SNF/NF: 29<br>Total: 29<br><br>Census Payor Type:<br>Medicare: 2<br>Medicaid: 15<br>Other: 12<br>Total: 29<br><br>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed August 11, 2023 | 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.<br><br>Thank you and have a great day!<br>Amanda Duggan, HFA | |
| F 0744<br>SS=D<br>Bldg. 00 | 483.40(b)(3)<br>Treatment/Service for Dementia<br>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Amanda Duggan | Health Facility Administrator | 08/25/2023 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155796 | A. BUILDING 00<br>B. WING | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CEDARS THE | 14409 SUNRISE CT<br>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 |
|---|---|---|---|---|
| | Based on observation, interview and record review, the facility failed to provide dementia care and services for 2 of 3 residents reviewed (Resident F and Resident H).<br><br>Findings include:<br><br>1. An Indiana report, dated 7/26/23, indicated Resident F was observed with purple bruising to both forearms. She indicated CNA 3 (Certified Nurse Aide) insisted she get up for breakfast; she hadn't wanted to and began to hit the CNA and told her to leave her alone.<br><br>On 8/8/23 at 10:20 A.M., Resident F was observed and interviewed in her room where she sat in her wheelchair. She immediately began to pull up her sweater sleeve on the right side and indicated she had bruises from care given by a CNA. She had a large purple bruise to the top of her right hand where her skin was extremely thin. She indicated the bruises kept happening because staff were "always in a rush" when giving her care. She got angry when they rush or don't listen to her when she says "no", so she yelled and tried to hit them. She indicated her current bruises occurred when a CNA tried to get her up for breakfast which she hadn't wanted to do, and had said "no". When the CNA continued to get her dressed, she yelled at her, told her to get the hell out of her room and hit her. When asked, she indicated she wanted to get up in the morning between 7:30-8:00 a.m. and go to bed at 7:30 p.m.<br><br>On 8/8/23 at 11:16 A.M., Resident F's record was reviewed. Diagnoses included dementia, depression, anxiety, delusional disorder and atrial fibrillation.<br><br>An annual MDS (Minimum Data Set) assessment, | F 0744 | =”” span=””><br>All residents will be interviewed to what their preferences for care are. Residents' preferences will be updated in their POC as well as assignment sheet. (See Attachment A) Staff will be educated on residents' rights, Dementia Protocol and Behaviors. Staff will be educated on approach and working with Dementia residents (See Attachment B1-B4) as well as Tracking and monitoring the behaviors. (See Attachment C) Audits will be completed daily for two weeks, weekly for four weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed daily and then monthly with the QAPI meetings. (See Attachment D) | 08/27/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155796 | A. BUILDING 00<br>B. WING | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CEDARS THE | 14409 SUNRISE CT<br>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 |
|---|---|---|---|---|
| | dated 5/5/23, indicated the resident had severely impaired cognition but had clear speech and was able to understand others and make herself understood. She had physical behaviors towards others 1-3 days of assessment but had not rejected care. Per resident interview, she indicated it was very important for her to choose her bedtime and do activities of her choice. She was non-ambulatory and required extensive assistance of 2 staff with bed mobility and transfers with a stand up lift. She was prescribed an anticoagulant (decreases blood from clotting; increases risk of bruising) to treat the atrial fibrillation.<br><br>Care plans included:<br><br>-3/2/20: The resident had dementia. Interventions included: cue, reorient and supervise as needed; use approaches that maximize her involvement in daily decision making and activities; use cueing and task segmentation; use her preferred name, identify yourself at each interaction, make eye contact, reduce distractions, use consistent, simple directive sentences, provide necessary cues, and stop and return if agitated.<br><br>-Initiated on 5/5/18 and revised 7/7/23, Resident F had behaviors of delusions/hallucinations, combativeness, verbal and physical aggression, refusal of care, and scratching. Interventions included: The resident's triggers for aggression were new caregivers as well as caregivers who were loud, and don't allow resident time to process. Her behaviors were de-escalated by leaving the room and allowing her to calm down.<br><br>-8/11/20: The resident had a delusional disorder. The goal was for her to remain safe. Interventions included: Triggers for verbal aggression were, being treated with a sharp tone, hurrying care, and | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155796 | A. BUILDING 00<br>B. WING | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CEDARS THE | 14409 SUNRISE CT<br>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 |
|---|---|---|---|---|
| | not allowing her to make choices. Her behaviors were de-escalated by leaving the room and allowing her to calm; caregivers may need to be changed; and when she becomes agitated, intervene before agitation escalates, guide her away from source of distress, engage calmly in conversation and if her response is aggressive, staff were to walk away calmly and approach her later.<br><br>A CNA assignment sheet (directed CNA's how to care for the residents) was provided by the DON (Director of Nursing) on 8/8/23 at 12:00 P.M. The assignment sheet indicated Resident F had dementia and if she started to get aggressive, staff were to ensure her safety, leave the room and get the nurse. The sheet hadn't indicated triggers for her behaviors which were: staff being loud and using a sharp tone of voice, not giving her time to process, hurrying her care and not allowing her to make choices.<br><br>A Social Services note, dated 7/26/23 at 1:02 p.m., indicated at 11:35 a.m., the resident had been interviewed related to the bruising on her arms. The resident recalled that a girl had tried to get her up out of bed and she hadn't wanted to. The girl wouldn't listen, was bossy, grabbed at her arms and hands, and got her up out of bed.<br><br>Confidential staff interviews indicated when Resident F said she didn't want to do something, staff needed to leave and re-approach her or she would get angry, lash out, yell, and become combative. When combative in bed, she would try and hit staff and hit her own arms and hands on her transfer bars which caused bruises. Staff weren't aware of when the resident wanted to get up in the morning or go to bed but she was the first one gotten up every morning by the day shift | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155796 | A. BUILDING 00<br>B. WING | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CEDARS THE | 14409 SUNRISE CT<br>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 |
|---|---|---|---|---|
| | at 6:00 a.m. When questioned, staff indicated behaviors were documented in PCC (Point Click Care-Electronic Health Record) under tasks and behaviors, and care was provided according to the CNA assignment sheet.<br><br>A written statement by CNA 3, provided by the DON on 8/8/23 at 12:00 p.m., indicated CNA 3 had been trying to put Resident F's pants on while she was lying in bed so she could be gotten up for breakfast. She had explained her plan to the resident. The resident hit her several times, tried to scratch her, and told her to get out of her room or she was going to kill her. CNA 3 finished pulling up her pants and then left the room to get assistance from CNA 5. She hadn't recalled the care sheet indicating the resident could stay in bed and hadn't experienced the behavior from her on other shifts.<br><br>On 8/8/23 at 1:49 P.M., CNA 5 was interviewed. She indicated CNA 3 came to get her and indicated she needed help getting Resident F up for the day because while trying to put the resident's pants on, she had become combative and tried hitting her. CNA 3 had to hold her hands to finish getting up her pants. She went to the resident's room with CNA 3 where the resident was lying in bed with her lower body dressed and upper body still needing done. Resident F saw CNA 5 and was immediately cooperative and anxious to show her the bruises on her arms. When asked about the bruises, the resident indicated she "hit her" (CNA 3) and started swinging her arms at CNA 3 and yelled at her to get out of her room. She agreed to get up and was assisted into her wheelchair. CNA 5 reported the behavior and bruises to the charge nurse. CNA 5 indicated she had worked with and observed CNA 3 with other residents and she was very kind and | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155796 | A. BUILDING 00<br>B. WING | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CEDARS THE | 14409 SUNRISE CT<br>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 |
|---|---|---|---|---|
| | respectful to the residents and they liked her. She indicated Resident F could get angry and combative but was easily redirected if left alone and re-approached. CNA 3 should've left the room as soon as the resident became combative rather than finish the task of pulling up her pants.<br><br>2. On 8/8/23 at 3:08 P.M., Resident H's record was reviewed. Diagnoses included dementia, generalized anxiety, depression, restlessness and agitation.<br><br>A quarterly MDS assessment, dated 7/27/23, indicated the resident had severely impaired cognition and rarely made decisions. She had moderate difficulty with hearing, had clear speech, was able to be understood and usually understood others. She had continuous behaviors of inattention and disorganized thinking. She was non-ambulatory and required extensive assistance of 1 for transfers and 2 staff for toileting. She needed extensive assistance for locomotion in her wheelchair.<br><br>Care plans included:<br><br>-7/15/20: The resident had dementia. Interventions included: ask yes/no questions; give her baby doll to hold; keep routine consistent, try to provide consistent care givers; and reminisce using photos of family.<br><br>-Initiated 4/26/18 and revised 7/7/23, Resident H had behavior problems of wandering/exit seeking, physical and verbal aggression, combativeness, self transfers, and refusals of care. Interventions included: distract when wandering and provide structured activities.<br><br>Progress notes indicated the following: | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155796 | A. BUILDING 00<br>B. WING | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CEDARS THE | 14409 SUNRISE CT<br>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 |
|---|---|---|---|---|
| | -7/4/23 at 7:55 a.m., it was reported by the CNA that the resident started yelling and pushing away from the wall when attempted to give shower. The CNA returned the resident to her room without giving a shower due to the behavior.<br><br>-7/17/23 at 8:02 a.m., the CNA notified the nurse, the resident had been combative during morning care and had hit the CNA with her left inner hand. Staff would monitor for bruising.<br><br>-7/28/23 at 9:33 p.m., During a skin assessment, the resident was observed with a bruise to her posterior right lower leg. She denied pain. Staff would continue to monitor.<br><br>-8/4/23 at 8:48 a.m., a Social Service note indicated the resident was on a behavior management program. The program included tracking behaviors in PCC and putting into a daily behavior log, discussing behaviors with IDT (Interdisciplinary Team) in morning meeting, referrals to psychologist as needed, psychotropic review and monthly auditing and monthly behavior meetings with Pharmacist. For the month of July, Resident H had 1 behavior of combativeness. Overall, precipitating events were linked to medical and cognitive antecedents (a thing or event existed before or logically precedes another). Interventions included utilizing dementia protocol, family consult/education, and medication changes.<br><br>During confidential interviews, staff indicated Resident H was often combative with care which routinely occurred when trying to assist the resident off of the toilet. CNA's documented behaviors in PCC and care was provided according to the CNA assignment sheet. The | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155796 | A. BUILDING 00<br>B. WING | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CEDARS THE | 14409 SUNRISE CT<br>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 |
|---|---|---|---|---|
| | CNA sheet indicated the resident preferred female caregivers, had dementia, used a wheelchair for mobility, needed assistance of 1 person and was incontinent.<br><br>Review of PCC for monitoring of behavior symptoms for July 2023, indicated behaviors occurred on the following days/times:<br><br>-7/3 at 3:59 a.m., yelling/screaming, kicking/hitting, pinching and scratching. At 9:49 p.m., the resident had wandering behaviors.<br>-7/10 at 9:59 p.m., yelling/screaming.<br>-7/16 at 1:58 a.m., kicking/hitting, grabbing and pinching/scratching.<br>-7/17 at 12:24 p.m., yelling/screaming, kicking/hitting and pinching/scratching.<br>-7/18 at 1:05 p.m., yelling/screaming and kicking/hitting.<br><br>On 8/9/23 at 1:45 P.M., the Social Services Director (SSD) was interviewed. She indicated nurses were to document behaviors in PCC in progress notes. She would review the progress notes daily and log them into a behavior log she maintained. New behaviors would then be discussed in morning meetings. She indicated the facility behavior management team was loosely organized and revolved around GDR's (gradual dose reduction of psychotropic medications) with the psychiatric NP (Nurse Practitioner) and hadn't met regularly. When questioned, she was not aware CNA's were documenting behaviors in PCC and hadn't known Resident H had behaviors other than the 1 episode documented in the progress notes. She indicated the facility used dementia protocol that was non-specific nor person-centered. When cause of dementia related behaviors were known, individualized interventions were placed on the care plan. The SSD indicated the cause of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155796 | A. BUILDING 00<br>B. WING | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CEDARS THE | 14409 SUNRISE CT<br>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 |
|---|---|---|---|---|
| | Resident F's dementia related behaviors were well known and documented on the care plan. The staff were expected to know and follow the plan.<br><br>On 8/9/23 at 2:01 P.M., the DON was interviewed. She indicated nurses were to document behaviors in PCC progress notes. She was not aware CNA's documented behaviors in PCC. She hadn't been aware of Resident H's behaviors or the bruise that had been found on 7/28. She indicated the bruise could have occurred when being provided care. However, Resident F's dementia related behaviors had been extensively documented and staff were aware of her behavior interventions. The interventions included giving her choices, leaving and re-approaching her when she was agitated or combative.<br><br>A copy of an undated form, titled "Dementia Protocol" was provided by the Administrator on 8/8/23 at 2:00 P.M., which listed 16 non-specific, generalized dementia care interventions which included: "6. Offer resident choices when possible...8. When agitated, remove yourself, if you are the focus of their agitation. You may find they calm down quickest alone...13. do not challenge, confront or argue with the resident-it will only confuse and anger the resident-power struggles are always a lose-lose situation...16. Demented often mimic your mood. Role model what you want back".<br><br>On 8/9/23 at 1:59 P.M., the SSD provided a current copy of an undated policy, titled "Behavior Management Policy". The policy indicated the following: "It is the intent of the Cedars to implement the 'Behavior Management' policy when any resident's behavior meets the below 'problematic' criteria. Staff at the Cedars will identify and refer problematic behaviors which | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155796 | A. BUILDING 00<br>B. WING | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CEDARS THE | 14409 SUNRISE CT<br>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 |
|---|---|---|---|---|
| | meet the criteria to the Behavior Management Team (BMT) either through documentation in PCC, verbally, or through the Social Service Referral Form...The BMT will review the reported new, continuing and/or worsening problematic behavior being exhibited to determine possible causes, precipitating, and/or contributing factors, and possible assessment and/or interventions needed. An individualized behavior care plan addressing the resident's behavior will be developed upon the completion of the assessment process. The Cedars will maintain a BMT which will be responsible for tracking, monitoring, and reviewing the behavior and effectiveness of interventions. Criteria: The Cedars considers resident behavior to be potentially problematic when: the behavior presents a risk of danger and/or harm to the resident...or others; the behavior significantly reduces staff's ability to provide care...infringes on the rights or dignity of others...Nursing or Social Services will document the behavior in PCC...The IDT will discuss any new, continued, or worsening behavior in the morning clinical meeting...The BMT will meet at least weekly to review and discuss behaviors...Individualized Behavior Care Plans will be created by Social Services and revised and monitored by MDS Coordinator...Monthly Behavior Management notes for resident's behavior that occurred over the previous month will be documented in PCC by Social Services...."<br><br>This Federal tag relates to Complaint IN00413820.<br><br>3.1-37 | | | |
| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint | R 0000 | We respectfully request | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155796 | A. BUILDING 00<br>B. WING | 08/09/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| CEDARS THE | 14409 SUNRISE CT<br>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 |
|---|---|---|---|---|
| | IN00413976. This visit included the Investigation of Nursing Home Complaint IN00413820.<br><br>Complaint IN00413976 - No deficiencies related to the allegations are cited.<br><br>Survey date: August 8 and 9, 2023<br><br>Facility number: 001215<br><br>Residential Census: 8<br><br>The Cedars was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaint IN00413976.<br><br>Quality review completed August 11, 2023 | | consideration for paper compliance. If you have any questions or concerns, please contact Amanda Duggan, HFA at 260-627-2191.<br><br>Thank you and have a great day!<br>Amanda Duggan, HFA | |