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	05/03/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: April 29, 30, May 1, 2, and 3, 2024. Facility number: 013144 Provider number: 155822 AIM number: 201246060 Census Bed Type: SNF/NF: 33 SNF: 20 Residential: 29 Total: 82 Census Payor Type: Medicare: 12 Medicaid: 27 Other: 14 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/8/24.	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.	
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 observation, record review, and	F 0677	F677	05/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Shelly Dyek | Executive Director | 05/17/2024

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	interview, the facility failed to ensure residents received the necessary care for activities of daily living care (ADL) related to long unkempt fingernails and the lack of offering residents shaving per the plan of care for 2 of 3 residents reviewed for ADL care. (Residents 21 and 26) Findings include: 1. On 4/29/24 at 11:19 a.m., Resident 21 was observed lying in bed in her room. Her fingernails were long, thickened and discolored. The resident indicated she would like them trimmed and no one had offered to trim them. On 5/1/24 at 11:07 a.m., and again on 5/2/24 at 9:07 a.m., Resident 21 was observed in her room. Her fingernails were still long, thickened and discolored. Record review for Resident 21 was completed on 5/1/24 at 2:33 p.m. Diagnoses included, but were not limited to diabetes mellitus, dementia, stroke, and Parkinson's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 2/21/24, indicated the resident was moderately cognitively impaired. The resident had an impairment on one side of the upper and lower extremities for a functional limitation in range of motion. The resident required a substantial assistance with personal hygiene. A Care Plan, dated 1/5/21 and revised 2/22/24, indicated the resident had a diagnosis of cerebrovascular accident (stroke) with right hemiparesis/hemiplegia (weakness, paralysis) requiring assistance with ADL care.		1 Residents 21 and 26 were affected with no negative outcomes. 2 All residents have the potential to be affected. All residents checked for nail care and shaving. 3 Nursing educated residents' preferences for nail care and shaving. 4 As a measure of ongoing compliance DHS or designee will audit 5 residents a week x 6 months. 5 The results will be documented on an audit form initiated by the facility and reported, reviewed, and trended for compliance through the campus QA for a minimum of 6 months.	

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	During an interview on 5/2/24 at 9:42 a.m., CNA 1 indicated residents' nails were offered to be cut when they receive bathing. This was her first shift back from being off for 5 days and she had noticed Resident 21's fingernails needed to be cut. During an interview on 5/2/24 at 11:45 a.m., the Director of Nursing (DON) indicated the nurse was able to soak the resident's fingernails, cut them a little and then clean underneath of them. The resident had a fungus on her nails and had an antifungal ointment applied to them daily. She acknowledged the staff should have attempted to soak and cut her fingernails before today. 2. On 4/29/24 at 10:00 a.m., Resident 26 was noted in bed. He had grown out facial hair and his hair was disheveled. On 4/30/24 at 2:43 p.m., Resident 26 was noted in his room in bed. He had facial hair and his hair was disheveled. Resident 26's record was reviewed on 4/30/24 at 2:58 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, cognitive communication deficit, and Parkinson's disease. A Care Plan, dated 4/5/23, indicated the resident required staff assistance to complete ADL tasks completely and safely. Interventions included, but were not limited to, offer facial shaving on shower days, as needed, or as requested. Notify nursing of refusals. There was no documentation available in the record related to the resident receiving assistance with shaving. During an interview on 5/1/24 at 10:55 a.m., the			

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	DON indicated the resident had an electric razor that had broken. They were trying to get it replaced, but the staff were unable to get in touch with the resident's son. The DON was unable to provide any further documentation. During a follow-up interview on 5/1/24 at 1:45 p.m., the DON indicated shaving was considered basic care and they do not have to document it in the record. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 3 of 3 residents reviewed for non-pressure related skin conditions. (Residents 38, 4, and 26) Findings include: 1. On 4/29/24 at 2:12 p.m., Resident 38 was observed sitting in her wheelchair in her room. Dark purple discolorations were noted to the tops of both hands and she had a bandaid on her right	F 0684	F684 1 Residents 38, 26 and 4 were affected with no negative outcomes. 2 All residents have the potential to be affected. All residents audited for skin tears and discolorations. 3 Nursing educated on monitoring of discolorations and skin tears weekly until healed. 4 DHS or designee to audit 5 residents a week x 2 months, 3 residents a week x 2 months, 1	05/14/2024

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	wrist. On 4/30/24 at 2:29 p.m., Resident 38 was observed sitting in her wheelchair in her room. The dark purple discolorations remained to the tops of both hands. She had bandaids on her left hand and right wrist. On 5/1/24 at 8:52 a.m., Resident 38 was observed sitting in her wheelchair in her room. The dark purple discolorations remained to the tops of both hands, and she had a bandaid on her right hand. Record review for Resident 38 was completed on 4/30/24 at 2:14 p.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, congestive heart failure. The Admission Minimum Data Set (MDS) assessment, dated 3/29/24, indicated the resident was cognitively impaired. She required substantial assistance with lower body dressing and partial assistance with upper body dressing. She had received antiplatelet medications. A current care plan, updated 4/29/24, indicated the resident was at risk for excessive bleeding and bruising due to her medications. The Medication Administration Record (MAR), dated 4/2024, indicated the resident was receiving clopidogrel (an antiplatelet medication) 75 mg (milligrams) daily. An Event, dated 3/22/24, indicated the resident was admitted with skin discolorations to the left elbow, left forearm, right elbow, right and left arms and hands. The event was closed on 3/27/24 and the evaluation note indicated the discolorations were in various stages of healing. There was a		resident weekly x2 months. 5 The results of the audit will be brought to QA, reported, reviewed, and trended for Compliance for 6 months or compliance is 100%.	

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	lack of any further follow up with the skin discolorations. A Progress Note, dated 4/30/24, indicated the resident had a blood draw to the right hand and a bandage was applied. A Progress Note, dated 4/28/24, indicated the resident had a blood draw to the right hand and a bandage was applied. A Progress Note, dated 4/24/24, indicated the resident had a blood draw to the left hand and a bandage was applied. The Weekly Skin Assessments, dated 4/12/24, 4/19/24, and 4/26/24, indicated there were old skin impairments but no new skin issues. During an interview with the Director of Nursing (DON) on 5/1/24 at 10:54 a.m., she indicated the resident had recent blood draws and was a hard stick, which is probably what caused the skin discolorations and was why she had the bandaids on. She would start a skin event. 2. On 4/29/24 at 2:05 p.m., Resident 4 was observed sitting in his wheelchair in his room. He had his right pant leg pulled up and was pointing at his right knee. The was a large scabbed area to his right knee. On 4/30/24 at 2:31 p.m., Resident 4 was observed sitting in his wheelchair in his room. He had both pant legs pulled up and the large scabbed area remained to his right knee. Record review for Resident 4 was completed on 4/30/24 at 11:37 a.m. Diagnoses included, but were not limited to, dementia, pulmonary fibrosis,			

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	and hyperlipidemia. The Admission Minimum Data Set (MDS) assessment, dated 3/16/24, indicated the resident was cognitively impaired. He was dependent on staff for lower body dressing and substantial assist with upper body dressing. A current care plan, updated 3/14/24, indicated the resident was at risk for alterations in skin integrity. The interventions included, " ...observe my skin during routine caregiving for acute changes...." A Progress Note late entry, dated 4/18/24 at 12:43 a.m., indicated the resident had a fall on 4/17/24 and was observed sitting at the foot of his bed. The note indicated, " ... Resident skin has no injuries. Right knee was red from kneeling on the floor. Is blanchable ...." There was lack of any further documentation to indicate the resident had a scabbed area to the right knee. The Weekly Skin Assessments, dated 4/15/24, 4/22/24, and 4/29/24, indicated there were old skin impairments but no new skin issues. During an interview with the Director of Nursing (DON) on 5/1/24 at 10:54 a.m., she indicated the resident had a fall on 4/17/24 and the nurse had documented the right knee was red. The area had probably scabbed over after that. There was no further monitoring of the right knee and the weekly skin assessments had not indicated any new areas of skin impairment. 3. On 4/29/24 at 10:00 a.m., Resident 26 was observed in his room. He had discolorations to his left forearm with a small abrasion. On 4/30/24 at 2:42 p.m., Resident 26 was observed in his room. He had discolorations to his left			

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	forearm with a small abrasion. Resident 26's record was reviewed on 4/30/24 at 2:58 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance and Parkinson's disease. The Annual Minimum Data Set (MDS) assessment, dated 3/5/24, indicated the resident was severely cognitively impaired for daily decision making. He required assistance from staff for activities of daily living (ADLs) including bathing and personal hygiene. A Care Plan, dated 5/17/23, indicated the resident had a potential for alterations in skin integrity. Interventions included, but were not limited to, complete a weekly skin assessment via a licensed nurse and observe the skin during routine caregiving for acute changes. There was no documentation available in the resident's record related to the abrasion and discoloration on the left forearm. During an interview on 5/1/24 10:55 a.m., the Director of Nursing indicated Resident 26 had self-propelled throughout the facility a lot. The staff had assessed the area and said it was an old abrasion from self-propelling. She was unable to provide any additional information. 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience			

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	reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary treatment to prevent a decrease in range of motion related to leg rests and a foot board improperly positioned on a wheelchair for 1 of 1 residents reviewed for positioning and mobility. (Resident 154) Finding includes: On 4/30/24 at 2:41 p.m., Resident 154 was sitting in a wheelchair in the dining area of the memory care unit on the Assisted Living side of the facility. The resident was sitting with other residents who were participating in an activity. The resident was observed to have leg rests and a foot board attached to the end of her wheelchair. The leg rests and footboard were extended horizontally out aligned with the wheelchair. Underneath the resident's legs and feet was a pillow on top of the leg rests. When the resident extended her feet they would extend over the foot board so she would then pull her legs back into a bent position. The resident had attempted multiple times to move	F 0688	F688 1 Resident 154 was affected with no negative outcomes. 2 All dependent residents with foot pedals could be affected. All residents audited for proper foot pedal placement for proper body alignment. 3 Nursing educated proper foot pedal placement for proper body alignment. 4 DHS or designee to audit 5 residents weekly x2 months, 3 residents weekly x2 months, 1 resident weekly x2 months. 5 As a measure of ongoing compliance, audits will be brought to QA, reported, reviewed, and trended for compliance for 6 months or until 100% compliance is achieved.	05/14/2024

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	her feet off of the leg rests and place them onto the floor. An Activity Aide was sitting next to the resident, and each time the resident attempted to put her feet onto the floor, the Activity Aide would place her feet back onto the leg rests and ask the resident to keep her feet in the wheelchair. During an interview at the time of this observation, Activity Aide 1 indicated the resident's feet were always up on the leg rests because she would try and stand and then would fall down. Record review for Resident 154 was completed on 4/30/24 at 11:55 a.m. Diagnoses included, but were not limited to, dementia, anxiety, right radius (forearm bone) fracture, and repeated falls. The Admission Minimum Data Set (MDS) assessment, dated 4/11/24, indicated the resident was severely cognitively impaired. The resident was dependent with transfers and used a wheelchair. A Care Plan, dated 4/4/24 and revised 4/29/24, indicated the resident was at risk for falling related to a history of falls, impulsiveness, and unsteady gait. Interventions included, fix left wheelchair brake, apply a wedge cushion to wheelchair seat, and staff to assist resident with transfers as needed. A Care Plan, dated 4/4/24, indicated the resident had a potential for decline in functional status related to dementia with a history of falls due to unsteady gait, being impulsive, arthritis and scoliosis. Interventions included for adaptive equipment as ordered, and to encourage the resident to do as much for self as safely possible. A Progress Note, dated 4/6/24 at 11:14 a.m.,			

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	indicated the resident was on the floor on her knees in the activity room. An IDT Progress Note, dated 4/6/24 at 1:43 p.m., indicated the resident a fall without injury on 4/6/24. The cause of the fall was moving her legs to the side of her chair, then attempting to stand. An intervention included to apply a wedge cushion to the wheelchair seat. Therapy services were aware. A Progress Note, dated 4/22/24 at 6:39 p.m., indicated staff were observed lowering the resident from her wheelchair foot pedals/board to the floor alongside dining table. The resident had exhibited baseline restlessness and mental status while "shimmying" from the seat of the wheelchair quickly to the foot pedals. The staff observed the wheelchair take a "teeter-totter"action when the resident's weight rested on the foot pedals. Three staff members intervened to lower the resident to the dining area floor. A Progress Note, dated 4/27/24 at 6:31 p.m., indicated the resident was in the dining room. The resident was placed at the table and the brakes were locked on the wheelchair. The resident was then observed pushing her chair back with her legs and feet over the side of the foot rest. The resident turned her wheelchair on its side. The resident's leg was still on the footrest. Staff assisted the resident up and back into her wheelchair. No injuries were noted at the time. The resident's daughter was informed of the incident and indicated that her mother was attempting to get up and putting her feet and legs over the foot rest earlier when she had visited. An Occupational Therapy Evaluation and Plan of Treatment with Certification Period: 4/4/24-5/3/24,			

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	indicated the resident's current seating was a standard wheelchair with adaptive equipment/devices including leg rests. The Occupational Therapy Evaluation did not include how high the leg rests should be attached to the wheelchair. During an interview on 4/30/24 at 2:57 p.m., the Director of Nursing (DON) indicated the resident had her feet and legs up on legs rests at all times and was unaware why. She would look into it. During an interview on 5/1/24 at 8:28 a.m., the DON indicated she had removed the resident's leg rests yesterday evening and observed the resident for a little while. The resident did try to move her feet around and use her hands to turn the wheelchair wheels. She also tried to stand so they had to assist her so she would not fall. She indicated the leg rests should not have been up that high since the resident was able to propel herself. She would speak to therapy to see if they recommended the leg rests and foot board. During a follow up interview on 5/1/24 at 8:48 a.m., the DON indicated therapy had recommended the leg rests and foot board for positioning. During an interview on 5/1/24 at 9:38 a.m., the Therapy Director (TD) indicated they did recommend the leg rests and foot board for positioning and for safety when staff propelled the resident in the wheelchair. The leg rests and foot board were intended for the resident to sit up straight. The positioning of the leg rests and footboard should be just off of the ground and not straight out horizontally from the wheelchair. The TD was unaware of the recent incidents in which the resident was involved with her almost			

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	tipping her chair when she sat on her leg rests, and then when she turned her wheelchair over in the dining room. She would in-service her staff to do better documentation on the assistive devices they recommend. The documentation should have included how high the resident's feet and legs should have been lifted off of the ground so the nursing staff would know. 3.1-42(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure a gastrostomy tube (g-tube) was properly checked for placement prior to medication administration	F 0693	F693 1 Resident 21 was affected with no negative outcomes. 2 All residents with peg tubes	05/14/2024

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	155822	A. BUILDING 00 B. WING	05/03/2024

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	for 1 of 16 residents observed during medication pass. (Resident 21) Finding includes: During a medication pass observation on 5/2/24 at 12:03 p.m., LPN 1 was observed preparing medications for Resident 21. She performed hand hygiene, popped two carbidopa 25 milligram (mg) tablets into a medication cup, poured the tablets into a crush bag, crushed the medication, and then put them back into the medication cup. She prepared two carbidopa-levodopa 25-100 mg tablets into a separate cup, crushed them in a bag, and then placed them back into the medication cup. She then mixed 15 milliliters (ml) of water with each medication and prepared two 30 ml and one 15 ml cup of water for flushes. Upon entrance to the resident's room, LPN 1 performed hand hygiene and donned a gown and gloves. She paused the g-tube feeding and then proceeded to check the resident's g-tube for placement with an air bolus by plunging air with a syringe into the tube. She poured a 30 ml flush into the tube, then the carbidopa medication, the 15 ml water flush, carbidopa-levodopa medication, then the 30 ml water flush. She reattached and resumed the g-tube feeding. During an interview on 5/2/24 at 12:21 p.m., LPN 1 indicated she was supposed to check for placement by removing residual from the g-tube per the facility policy, not with an air bolus. During an interview on 5/2/24 at 3:48 p.m., the Director of Nursing indicated she had no further information to provide. A Policy titled, "Specific Medication		could be affected. 3 Nurses educated on enteral medication administration. 4 DHS or designee to audit medication pass with 3 nurses a week x 4 weeks, 3 nurses every other week x 4 weeks, 3 nurses a month x4 months. 5 As a measure of ongoing compliance, audits will be brought to QA, reported, reviewed, and trended for compliance for 6 months or until 100% compliance is achieved.	

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	Administration Procedures," indicated "...L. With gloves on, check for proper tube placement using air and auscultation only. Never check placement with water. M. Check gastric content for residual feeding. Return residual volumes to the stomach. Report any residual about 100 ml." 3.1-44(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications were stored	F 0761		05/14/2024

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	appropriately related to unidentified and crushed pills found in medication cart drawers for 2 of 2 medication carts reviewed. (100 and 300 Hall carts) Findings include: 1. The 100 Hall Medication Cart was observed on 5/2/24 at 9:06 a.m. with RN 1. Upon review, there were multiple unidentified whole pills on the bottom of the drawer. The corner of the third drawer was covered with crushed up medications. During an interview at the time, RN 1 indicated the night shift staff was supposed to clean out the medication carts during their shift. During an interview on 5/2/24 at 8:58 a.m., the Director of Nursing was notified of the medications found in the medication cart and she had no further information to provide. 2. The 300 Hall Medication Cart was observed on 5/2/24 at 1:51 p.m. with RN 2. Upon review, there were two unknown whole pills on the bottom of the drawer. During an interview at the time, RN 2 indicated the night shift staff was supposed to clean out the medication carts during their shift. During an interview on 5/2/24 at 8:58 a.m., the Director of Nursing was notified of the medications found in the medication cart and she had no further information to provide. A Policy titled, "Medication Storage in the Facility," indicated, "...C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label... H. Outdated, contaminated, or deteriorated medications and		1 No residents were affected per 2567 DHS or designee completed cart reviews to ensure medications are not loose in the cart. 2 All residents could be affected. All medication carts will be audited to ensure proper storage. 3 Nursing staff educated on proper medication storage. 4 As a measure of ongoing compliance, DHS or designee will 1 audit medication cart 3x week x2 months, 2x weekly x2 months and weekly x2 months. 5 The results of the audits will be documented on an audit form initiated by the facility and reported, reviewed, and trended for compliance through the campus Quality Assurance Program (QA) for a minimum of 6 months.	

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	those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal..." 3.1-25(o)			
F 9999 Bldg. 00	3.1-18 INFECTION CONTROL PROGRAM (b) The facility must establish an infection control program under which it does the following: (7) Reports communicable disease to public health authorities. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to establish an Infection Control program which included a system that reported communicable disease to public health authorities related to not reporting COVID-19 positive staff and resident cases to the Indiana Department of Health (IDOH) as required. This had the potential to affect all 53 residents in the facility. Finding includes: Review of the facility's Infection Control binder was completed on 5/2/24 at 10:25 a.m. The infection line listing indicated during 2/25/24-3/1/24, the facility had 4 residents on the same unit and 3 staff members test positive for COVID-19. During an interview on 5/3/24 at 11:07 a.m., the Infection Preventionist was unsure if the outbreak was reported to IDOH.	F 9999	F9999 1 No residents were affected per 2567. 2 All residents could be affected. Clinical support to educate administration and management of reporting COVID positive outbreaks per guidance to the Indiana State Department of Health. 3 As a measure of ongoing compliance, ED or designee will review COVID positive residents, as applicable, for outbreak criteria 5 times a week for 4 weeks then 3 times a week for 5 months to ensure accurate reporting as applicable. 4 As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings for 6 months or until 100% compliance is achieved.	05/14/2024

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	During an interview on 5/3/24 at 11:56 a.m., the Administrator indicated the COVID-19 outbreak was not reported to IDOH. The IDOH Policies and Procedures titled, "Long-Term Care Abuse and Incident Reporting Policy" indicated, "COMPREHENSIVE CARE FACILITIES"..."B. Types of Incidents Reportable Under Federal and State Rules"..."4. Epidemic outbreaks a. Required to report at least three residents with the same infection in one defined area (such as hall, unit, neighborhood, street, pod, secured unit, vent unit) in a 48-hour period; or 10% or more of the current building census with the same infection...."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: April 29, 30, May 1, 2, and 3, 2024. Facility number: 013144 Residential Census: 29 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/8/24.	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	

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			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.	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.			

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	(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on record review and interview, the facility failed to report a COVID-19 outbreak in the facility to the Indiana Department of Health (IDOH). This had the potential to affect all 29 residents residing in the facility. Finding includes: Review of the facility's Infection Control binder was completed on 5/2/24 at 1:35 p.m. The infection line listing indicated, during 11/27/23-12/4/23, the facility had 8 residents and 1 staff member test positive for COVID-19. During an interview on 5/2/24 at 2:54 p.m., the Administrator indicated the COVID-19 outbreak was not reported to IDOH. The IDOH Policies and Procedures titled, "Long-Term Care Abuse and Incident Reporting Policy" indicated, "LICENSED RESIDENTIAL	R 0090	R0090 1 No residents were affected per 2567. 2 All residents could be affected. Clinical support to educate administration and management of reporting COVID positive outbreaks per guidance to the Indiana State Department of Health. 3 As a measure of ongoing compliance, ED or designee will review COVID positive residents, as applicable, for outbreak criteria 5 times a week for 4 weeks then 3 times a week for 5 months to ensure accurate reporting as applicable. 4 As a quality measure, the ED or designee will review any findings and corrective action at	05/14/2024

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	CARE FACILITIES"..."C. Types of Incidents reportable under state rules...Any occurrence that directly threatens the welfare, safety, or health of a resident, such as:"..."4. Epidemic outbreaks: Required to report at least three residents with the same infection in one defined area (such as hall, unit, neighborhood, street, pod, secured unit, vent unit) in a 48-hour period, or 10% or more of the current building census with the same infection AND required communicable disease reporting per current state standards and guidelines...."		least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings for 6 months or until 100% compliance is achieved.	