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	02/17/2025

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 the Investigation of Complaint IN0451146. Complaint IN00451146 - No defiencies related to the allegations are cited. Unrelated deficiency is cited. Survey date: February 17, 2025. Facility number: 001215 Provider number: 155796 AIM number:100450890 Census Bed Type: SNF/NF: 39 Residential: 8 Total: 47 Census Payor Type: Medicare: 1 Medicaid: 20 Other: 26 Total: 47 This deficiency reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality reivew completed February 17, 2025	F 0000	=”” span=””> 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 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review the facility failed to ensure fall interventions were followed for 1 of 3 residents reviewed (Resident B).	F 0689	All residents have the right to be Free of Accidents Hazards/Supervision/Devices. This requirement was not met by the	02/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Duggan	Administrator	02/27/2025

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: A facility reported incident, dated 2/15/25, was provided by the Administrator on 2/17/25 at 10:58 AM. The report indicated Resident B had a fall with resultant fracture involving the distal fibula with no displacement. Resident B's record was reviewed on 2/17/25 at 11:25 AM, diagnosis included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and dementia. A nursing note, dated 2/15/25, indicated Resident B was found in the bathroom at 9:40 AM alone on the floor due to a self transfer. The note indicated Qualified Medication Aide (QMA) 3 assisted Resident B onto the toilet, exited the room, then found Resident B on the bathroom floor around 10 AM. A nursing note, dated 2/15/25, timed 3:11 PM, indicated Certified Nurse Aide (CNA) 4 noticed swelling and bruising at Resident B's ankle. An X-ray was ordered and indicated a fracture involved the distal fibula with no displacement. A care plan note, dated 2/12/25, indicated a new fall intervention was added to the CNA sheet to not leave Resident B in the bathroom alone/unattended. Resident B's current care plan indicated she was at risk for falls related to confusion, gait/balance problems, incontinence and was unaware of safety needs. During an interview, on 2/17/25 at 11:28 AM, the Administrator indicated on 2/15/25 Resident B was found on the bathroom floor around 9:40 AM		facility failed to ensure fall interventions were followed for 1 of 3 residents reviewed. All residents have potential to be affected by this requirement not being met. All residents will be reviewed for fall interventions being on the CNA assignment sheet as well as all staff will be re-educated on the fall interventions and spot checks will be completed as to the correct interventions. (Attachment A) Spot Checks will be completed by DON or Designee for two weeks, weekly for eight weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed daily and then monthly with the QAPI meetings. (Attachment A)	

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	due to attempt to self transfer onto the toilet. The Administrator indicated Resident B was assessed and then assisted onto the toilet by QMA 3. The Administrator indicated QMA 3 left Resident B on the toilet alone, exited the room and returned to find Resident B on the floor around 10 AM. The Administrator indicated staff should not have left Resident B on the toilet alone. During an interview, on 2/17/25 at 12:01 PM, CNA 2 indicated fall interventions for resident's at risk for falls are posted in the resident room and/or on the certified nurse aide sheet. CNA 2 indicated a CNA sheet was obtained at the beginning of each shift and as needed. CNA 2 indicated the sheet included resident information regarding assistance needed and special notes, including fall risk/interventions in place for the resident. A current CNA sheet was provided by the Administrator on 2/17/25 at 12:37 PM, the CNA sheet indicated Resident B was a high fall risk and was not to be left in the bathroom unattended/alone. A policy, dated 2024, titled "Fall Prevention Program," was provided by the Administrator on 2/17/25 at 12:37 PM. The policy indicated the nurse will indicate on the CNA sheet the resident's fall risk and interventions. 3.1-45(a)			