STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDAR CREEK OF BEDFORD	3008 SHAWNEE DR S BEDFORD, IN 47421

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: March 11 and 12, 2024 Facility number: 004011 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 14, 2024.	R 0000		
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the			

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

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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	resident understands. Based on observation and interview, the facility failed to ensure a copy of the residents' rights was available in a publicly accessible area for 2 of 2 days during the survey. Finding includes: On 3/11/24 at 3:10 p.m., no posting of the residents' rights was observed in the facility On 3/12/24 at 2:45 p.m., no posting of the residents' rights was observed in the facility. During an interview on 3/12/24 at 3:30 p.m., the Administrator indicated there was no posting of the residents' rights posted in a publicly accessible area.	R 0026	R0026 It is the practice of Cedar Creek Bedford to post resident rights in the community, at front entrance. **What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?** Executive Director Educated and Resident Rights poster was posted at the front entrance on 3/12/24. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents had the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** All staff have been in-service on the Resident Rights location by 3/21/24. **How the corrective action will be monitored to ensure the deficient practice does not reoccur?** The Executive Director or designee will monitor posters remain in place. This will be completed weekly times four weeks and then monthly, to evaluate if auditing needs to continue. The leadership team will	03/21/2024

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			determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing. **Date to be completed.** **3/21/2024**	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with			

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	dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure staff completed annual Resident Rights inservice training for 3 of 5 employee records reviewed. (QMA 1, LPN 1, Environmental Services Staff 1) Findings include: On 3/12/24 at 10:34 a.m., the Administrator (ADM) provided the employee files. A review of the files indicated the following: 1. QMA 1's employee file lacked documentation of her completing an annual Resident Rights inservice. 2. LPN 1's employee file indicated her last Resident Rights inservice was on 8/31/22. The employee file lacked documentation of her completing an annual Resident Rights inservice. 3. Environmental Services Staff 1's employee file indicated her last Resident Rights inservice was on 10/30/22. The employee file lacked documentation of her completing an annual Resident Rights inservice. On 3/12/24 at 3:00 p.m., the ADM indicated she could not locate any additional inservice trainings for the employees.	R 0120	**R 117 410 IAC 16.2-5-1.4(b) Personnel - Deficiency** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** An audit took place on 3/12/24 of staff charts to identify all staff members who did not have a current Resident Rights in-service. Those staff members who were identified as not having current were informed and will be scheduled to attend future Resident Rights in-service meetings. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents had the potential to be affected by this deficient practice. Executive Director (ED) or designee will review the staffing files to ensure there is updated	03/27/2024

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	On 3/11/24 at 3:30 p.m., the ADM provided the facility policy, "Resident Rights & HIPAA," updated 11/29/23, and indicated it was the policy currently being used by the facility. A review of the policy did not specify for staff to complete annual Resident Rights inservice training.		Resident Rights in their file. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The Executive Director (ED) and Director of Nursing (DON) were re-educated on 3/12/2024 on the Indiana State rule to ensure all staff have annual Resident Rights Inservice. Current staff who are not in compliance with this state rule will be in service by 3/27/2024. New staff will be given the Resident Rights in-service upon hire, all files will then be audited by ED or designee for compliance they have the Resident Rights Inservice. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director or Designee is responsible for sustained compliance. Employee files will be audited monthly to ensure compliance. The leadership team will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be ongoing.	

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			5. By what date will the systemic changes be completed? 3/27/2024	