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	09/04/2024

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 the Investigation of Complaints IN00438053 and IN00441626. Complaint IN00438053 - Federal/State deficiencies related to the allegations are cited at F744. Complaint IN00441626 - Federal/State deficiencies related to the allegations are cited at F744. Survey dates: September 3 & 4, 2024 Facility number: 013144 Provider number: 155822 AIM number: 201246060 Census Bed Type: SNF/NF: 32 SNF: 20 Residential: 32 Total: 84 Census Payor Type: Medicare: 16 Medicaid: 25 Other: 11 Total: 52 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/6/24.	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 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on record review and interview, the facility failed to ensure a resident with a diagnosis of	F 0744	1.All residents with dementia and a BIMS less than 9 were	09/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelly Dyek	Executive Director	09/20/2024

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	dementia and refusals to be bathed, received bathing at least twice a week and failed to ensure the resident's plan of care and interventions reflected the behavior of bathing refusals, for 1 of 3 residents with cognitive impairment reviewed for activities of daily living (ADL) status and behaviors. (Resident E) Finding includes: During an interview on 9/3/24 at 4:35 p.m., Resident E indicated she had not had a shower/bath since admission into the facility and was unable to remember if bathing had been offered to her. Resident E's record was reviewed on 9/4/24 at 10:54 a.m. The diagnoses included, but were not limited to, dementia. A Life Enrichment Assessment, dated 7/29/24 at 11:31 a.m., indicated it was very important for her to choose the type of bathing received and showers were preferred. A Care Plan, dated 7/29/24, indicated assistance was required for ADL's. The interventions were all dated 7/29/24 and indicated the resident was not to be rushed, encouragement was to be given to do as much as possible for herself, facial shaving was to be offered on shower days and the nurse was to be notified if refused, rest periods would be provided, nail care was to be provided on shower days, and therapy would evaluate and treat as needed. A Social Service Comprehensive Note, dated 7/31/24 at 12:00 p.m., indicated there were no behaviors, no care rejection behaviors, and no mood concerns.		reviewed for refusals. Residents with refusals identified were noted with no negative outcomes. 2.Social Service Directors, MDS and nursing staff educated on bathing preferences, care refusals, interventions and care planning. 3.As a measure of ongoing compliance, DHS or designee will perform audits of 5 residents daily for 1 month, 3 residents daily for 1 month then 5 residents a week for 4 months. 4.As a quality measure, the DHS or designee will review any findings and corrective action at least monthly in the campus Quality Assurance Performance Improvement meetings for 6 months or until 100% compliance is achieved. The plan will be reviewed and updated as warranted.	

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	An Admission Minimum Data Set assessment, dated 7/31/24, indicated a moderately impaired cognitive status, no behaviors, and required moderate assistance with showers/bathing. The computer point of care (POC) documentation, indicated a shower was received on 8/13/24, 8/16/24, and 9/3/24. The shower/bathing was refused on 7/30/24, 8/2/24, 8/6/24, 8/9/24, 8/20/24, 8/23/24, 8/27/24, and 8/30/24. There was no documentation in the Progress Notes, dated 7/27/24 through 9/4/24, that indicated the shower/bathing was refused. The behavior POC, dated 7/27/24 through 9/4/24, indicated there were no behaviors, including refusal of care. A Care Plan, dated 9/4/24, indicated the resident was non-compliant with physician's orders and the plan of care related to shower refusals and refusals of hands on care. The interventions, all dated 9/4/24, indicated the physician's orders with risks and benefits of compliance would be discussed with the resident and encouraged to participate in care plan and decision making. The resident would be encouraged to participate in decision making by offering choices and discussion of advance directives. She would be monitored for the ability to give informed consent and assessed for the need for a guardian or other legal oversight as needed. During an interview on 9/4/24 at 11:20 a.m., the Director of Nursing (DON) indicated the resident refused the showers due to weakness. The refusals were a behavior associated with the dementia. There was no documentation the Social			

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	Service Director was notified of the behaviors. The refusals of showers had not been found when audited. During an interview on 9/4/24 at 11:29 a.m., the Social Service Director indicated she had not been contacted about the refusals. Behaviors were usually documented in the record and then a care plan would be initiated with interventions. She was unaware the showers were refused. During an interview on 9/4/24 at 12:05 p.m., the DON indicated she picked five residents at random each week for bathing audits. When she looked at the resident's bathing, a shower had been given on 8/13/24 and continued monitoring was not triggered. The showers were scheduled on Tuesdays and Fridays on the day shift. The DON provided documentation from the audit sheets that indicated on 7/30/24, the resident refused the shower three times, on 8/2/24 and 8/27/24 the shower was refused due to weakness, 8/20/24 the shower was refused due to awakened too early, and 8/30/24 the shower was refused with no reason documented. The DON indicated there were no behaviors documented on the POC documentation or the Progress Notes in the record. A facility policy, titled, "Guideline for Mental Health Wellness Program", dated 12/31/23 and received as current from the DON, indicated behaviors were to be assessed and evaluated as part of the admission process. An attempt to determine the root cause would be assessed. Behavior interventions would be communicated to the interdisciplinary team for implementation. New behaviors were to be brought to the daily stand up meeting. The Social Service Director would review the documentation to determine if the			

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	behavior was isolated and causative factors. The Mental Health Wellness/Behavior Management Program would consist of a care plan with realistic and effective interventions. This citation relates to Complaints IN00438053 and IN00441626. 3.1-37			