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	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARS THE	14409 SUNRISE CT LEO, IN 46765

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00437842 and IN00438240. Complaint IN00437842 - No deficiencies related to the allegations are cited. Complaint IN00438240 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: July 18, 19, and 22, 2024. Facility number: 001215 Provider number: 155796 AIM number: 100450890 Census Bed Type: SNF/NF: 40 Residenial: 8 Total: 48 Census Payor Type: Medicare: 3 Medicaid: 21 Other: 24 Total: 48 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 23, 2024	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. Thank you and have a great day! Amanda Duggan, HFA	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and	F 0684	F684 Quality of Care CFR(s):	08/09/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda M Duggan	Health Facility Administrator	08/09/2024

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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	interview the facility failed to ensure there was an assessment and documentation of resident's dislodged PICC (peripherally inserted central catheter) line (thin, soft tube inserted into a vein in the arm, leg or neck for long-term intravenous antibiotics, nutrition, medications, and blood draws) and PICC line site in 1 of 1 resident reviewed (Resident C). Findings include: An Indiana report form, dated 7/17/24 at 7:01 AM, indicated during morning care Certified Nursing Aide (CNA) 2 noticed Resident C's Peripherally Inserted Central Catheter (PICC) line was out of her arm. The resident indicated she was not sure how it came out. Resident C's record was reviewed on 7/17/24 at 9:42 AM. Diagnoses included sepsis, metabolic encephalopathy, and diverticulitis of the large intestine with perforation and abscess with bleeding. Resident C's current Comprehensive Minimum Data Set (MDS), dated 7/2/24, indicated her Basic Interview for Mental Status (BIMS) score was 14 (cognitive intact). The MDS indicated she had recent open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair) surgery involving the gastrointestinal tract and required wound care. The MDS indicated the resident was on antibiotics, diuretics, opioids, was on IV medication and had IV access. Resident C's current Care plan, revised 7/11/24, indicated the resident had IV (intravenous) medications related to her infection in the colostomy stoma with a goal she would be free		483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure there was an assessment and documentation of resident's dislodged PICC (peripherally inserted central catheter) line (thin, soft tube inserted into a vein in the arm, leg or neck for long-term intravenous antibiotics, nutrition, medications, and blood draws) and PICC line site in 1 of 1 resident reviewed (Resident C). 1 Corrective Action accomplished for residents affected by the deficient practice: Both of the antibiotics administered via PICC line were d/c for Resident C per infectious disease visit on 7/17/24 immediately following dislodgement of PICC line; infectious disease follow up PRN. 2 How other residents having the potential to be affected by the	

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	from complications related to her IV therapy with a target date of 10/2/24. Interventions included: 1) If IV infiltrated antidote for vesicant/irritant medication may be infused into the IV catheter prior to removal. 2) If IV infiltrated stop infusion and thoroughly examine the site ...remove the cannula, elevate the arm, notify the physician. 3) Change dressing as ordered and observe every shift. 4) Monitor/document/report signs and symptoms of infection as needed. 5) Monitor/document/report signs and symptoms of IV fluid leakage at the insertion site. Physician orders dated 6/25/24 at 22:00 indicated Resident C's PICC line was to be maintained, could be used for law draws, and to apply biopatch to the PICC line. The order was discontinued on 7/17/24. Resident C's Treatment Administration Record (TAR), dated 7/1/24 through 7/16/24 indicated the facility staff documented the resident's PICC line was to be maintained, could be used for lab draws, and to apply biopatch to PICC line days, evenings, and nights except on the following dates: 7/6/24, 7/13/24 on days and 7/5/24, 7/11/24, and 7/16/24 on evenings. A witness statement by CNA 2 indicated she was doing morning care when she noticed Resident C's PICC line was out. She indicated she asked her what happened, and the resident indicated she was not sure, it must had been pulled out. CNA 2 indicated she took the PICC line to Licensed Practical Nurse (LPN) 4 and reported what Resident C told her. In an interview on 7/22/24 at 8:35 AM LPN 4 indicated on 7/17/24 around 6:10 AM CNA 2 brought Resident C's PICC line to her. She		same deficient practice will be identified and what corrective action(s) will be taken: Resident roster and current orders were reviewed 8/3/24 and determined to not have any PICC lines in the building currently. 3 The following measures / systemic changes were put in place to ensure that the deficient practice does not recur: A PICC line report sheet was created to document any PICC lines (Attachment A) Instructions when discontinuing a PICC line was created (Attachment B) The standards outlined in the policy entitled Central Lines (Attachment C) and the guidance on Central Venous Catheter Care & Maintenance (Attachment D) was reviewed with all nurses (Attachment E) 4 How the corrective action will be monitored to ensure the deficient practice will not recur: A monitoring form was created (Attachment F) for the Director of Nursing to review and sign off ensuring there was a line and site assessment completed and documented in the medical record for any PICC line removals or PICC line dislodgement. The Monitoring Sheet will be submitted to the Administrator monthly and reviewed at QAPI meetings for a period of six months. If after a period of six months, all	

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	indicated CNA 2 indicated the resident had just handed it to her. LPN 4 indicated there was a small amount of dried bright red blood on the tip of the PICC line. LPN 4 indicated she went in the resident's room and checked the site. She indicated the dressing was still intact at the PICC line site on the resident's left upper arm and there was no blood on the dressing. She indicated she did not remove the dressing. She indicated she did not measure the length of the PICC line after it came out of Resident C's arm or document, however she did report the PICC line being out to the physician. No orders were given. In an interview on 7/22/24 at 8:31 AM LPN 3 indicated she observed CNA 2 bring Resident C's PICC line to the nurses' station area and hand it to LPN 4. She indicated she did not observe the resident's PICC line. No progress note could be located relating to the 7/17/24 dislodgement assessment and documentation of Resident C's PICC line and/or left upper mid anterior PICC line site. No information was provided related to the 7/17/24 dislodgement assessment and documentation of Resident C's PICC line and/or left upper mid anterior PICC line site. In an Interview on 7/22/24 at 12:06 PM the Director of Nursing indicated the dislodged PICC Line and the PICC line site should had been assessed and documented and it was not . A current policy, dated 6/24/24, titled, "Central Lines Policy/Procedures", provided by the DON on 7/22/24 at 1:43 PM, indicated when a PICC line was discontinued the length of the PICC line, the intactness of the catheter tip, the site appearance,		appropriate assessments were completed and documented then monitoring may be reduced to periodic spot check audits to ensure ongoing compliance. 5 By what date the systemic changes for the deficiency will be completed: August 9, 2024	

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	and dressing applied needed to be documented. 3.1-37			