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	02/14/2024

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CEDAR CREEK OF MUNCIE	2410 E MCGALLIARD RD MUNCIE, IN 47303

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00425042 and IN00426162. Complaint IN00425042 - No deficiencies related to the allegations are cited. Complaint IN00426162 - No deficiencies related to the allegations are cited. Survey dates: February 13 and 14, 2024 Facility number: 004428 Residential Census: 45 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 20, 2024.	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dee Dee Wiley	Executive Director	03/02/2024

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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	conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure a fire drill was completed on each shift quarterly to ensure resident safety in the event of a fire emergency. This deficiency had the potential to affect 45 of 45 residents who resided in the facility. Finding includes: A review of the facility fire drills record, on 2/13/24 at 4:00 p.m., indicated they were held from 2/2/23 to 2/13/24 on the following dates, times, and shifts: a. 2/2/23 at 11:00 a.m.- first, second, and third shifts b. 3/22/23 at 11:00 p.m. - third shift c. 4/2/23 at 7:00 a.m. - first shift d. 6/1/23 at 2:00 p.m. - second and third shifts e. 6/18/23 at 10:00 p.m. - third shift f. 7/10/23 at 8:00 a.m. - first shift g. 8/28/23 at 11:00 a.m. - first shift h. 12/15/23 at 10:00 p.m. - third shift i. 12/21/23 at 9:20 a.m. - first and second shifts The record lacked documentation of fire drills completed during 9/23, 10/23, and 11/23. Only first shift received a fire drill in the third quarter. With the exception of 12/21/23 drills, all of the	R 0092	R092 **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The Environmental Services Director has been re-educated on the timeliness and frequency of fire drills as per the state regulatory requirements. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?** A fire drill has been conducted on all three shifts and documented accordingly. Drills were conducted on the following dates- 1st shift on 2/16, 2nd shift on 2/24, 3rd shift on 2/29. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Fire drills will be conducted on	03/15/2024

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	above mentioned fire drills lacked the attendees and their signatures. During an interview on 2/13/24 at 4:28 p.m., the Administrator indicated there had been a misinterpretation of the requirements for fire drills. They had not been completed as required. A fire drill on each shift should have been conducted quarterly. Further fire drill documentation was not available. During an interview on 2/14/24 at 2:09 p.m., the Maintenance Director indicated he conducted all the fire drills for the facility. Until recently, he was unaware fire drills should be conducted once each shift per quarter. The fire drills conducted from 2/2/23 to current had not met the requirements. He was unable to provide any further fire drill documentation. A current facility policy, undated, titled "Staff In-Service and Fire Safety Training Policy & Procedures," provided by the Administrator on 2/13/24 at 4:48 p.m., indicated the following: "Policy: Community staff shall be instructed and trained in various fire and life safety procedures and devices... Procedures: A fire drill or in-service staff training session is required on each shift, every month in the following schedule: 1) Fire Drill: Must be conducted once per quarter on each shift...."		each shift quarterly, 12 drills annually and recorded. **How the corrective actions will be monitored to ensure the deficient practice will no recur i.e. what quality assurance program will be put into place?** The Environmental Service Director will be responsible for performing and recording drills monthly. The TELS system will be utilize to monitor compliance. Executive director or designee will conduct monthly audits for 3 months to ensure that at least one fire drill has been completed on each shift quarterly and recorded appropriately. TELS alerts for upcoming drills will be discussed by the IDT team in morning stand up meetings. Date of compliance: 3/15/2024	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references			

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	and any convictions in accordance with IC 16-28-13-3. Based on observation, interview, and record review, the facility failed to complete a pre-employment screening prior to employment for 1 of 5 staff members reviewed for employee records. (CNA 4) Findings include: CNA 4's employee records were reviewed on 2/14/24 at 2:00 p.m. CNA 4 was hired on 11/1/23. The personnel file lacked pre-employment references. Review of the worked schedule, on 2/13/24 at 1:34 p.m., indicated CNA 4 worked the following dates on day shift the week of 2/5/24 to 2/11/24: 2/5/24, 2/8/24, 2/9/24, 2/10/24, and 2/11/24. During an interview on 2/14/24 at 2:30 p.m., the Administrator indicated the State Criminal Background Check and references were required to be completed prior to employment. During an interview on 2/14/24 at 5:14 p.m., the Administrator indicated she had identified employee records concerns when she hired on 1/15/24, but was unable to get it corrected prior to survey entrance conference. She was unable to provide any additional employee records. A current facility policy, dated 7/30/20, titled "New Hire Policy & Procedures," provided by the Administrator on 2/14/24 at 5:55 p.m., indicated the following: "Policy: The Community is responsible for complying with all applicable laws and Indiana State Department of Health Regulations... Procedures... 6) Business Office Manager [BOM] then has them fill out all	R 0116	R 116 **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** An audit was conducted of all current employee records to identify any other employees lacking pre-employment references or criminal background checks. Results of audit were discussed in morning stand up with the IDT team and the policy pertaining to pre-employment screening was reviewed. **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?** Employee references and criminal background checks will be obtained on all current employees as needed per facility audit of all employee records. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**. Business office personnel responsible for maintaining employee records will be trained upon hire on the required pre-employment screenings. The facility will refer to the Employee	03/15/2024

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	additional new hire paperwork as outlined in the New Hire Checklist [Indiana]... 12) The New Employee Hiring Checklist... will be filed in the employee's personnel file and maintained...." A current facility document, last updated 10/2022, titled "New Employee Hiring Checklist (Indiana)," provided by the Administrator on 2/14/24 at 5:55 p.m., indicated the following: "... Documents for Employee's Confidential RED Personnel File: ...Required - Past Employment Phone and/or Written Reference Check Forms [Recommended: 2 professionals, 1 personal]...."		Record State Form 5440 as a compliance tool to ensure all necessary pre screenings are completed in the appropriate time frames. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** An audit will be conducted weekly of at least 3 employee personnel files for 3 months or until 100% compliance is achieved. Audit to be completed by Executive Director or designee. Date of Compliance: 3/15/24	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall			

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	have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure each shift was staffed with at least one staff member certified in cardiopulmonary resuscitation (CPR) and First Aid. This deficient practice had the potential to affect 45 of 45 residents who resided in the facility. Findings include: 1. Review of the employee schedule from 2/7/24 to 2/13/24 indicated a lack of a staff member on duty with a CPR certification for 11 out of 21 shifts reviewed as follows: a. 2/7/24 - second and third shifts b. 2/8/24 - third shift c. 2/9/24 - third shift d. 2/10/24 - first, second, and third shifts e. 2/11/24 - second and third shifts f. 2/12/24 - third shift g. 2/13/24 - third shift 2. Review of the employee schedule from 2/7/24 to 2/13/24 lacked a staff member on duty with a First Aid certification for 21 of 21 shifts reviewed as follows: a. 2/7/24- first, second, and third shifts b. 2/8/24- first, second, and third shifts c. 2/9/24- first, second, and third shifts d. 2/10/24- first, second, and third shifts e. 2/11/24- first, second, and third shifts f. 2/12/24- first, second, and third shifts g. 2/13/24- first, second, and third shifts	R 0117	**R117** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** An audit of employees First Aid and CPR certifications was conducted and reviewed by the Director of Nursing and Executive Director. **How the facility will identify other residents having the potential to be affected by the same deficient practice what corrective actions will be taken?** A CPR and First Aid class has been scheduled on March 4th at 9am to ensure that at least one staff member is on shift with the appropriate certification. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** Work schedules will be reviewed	03/15/2024

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	During an interview on 2/14/24 at 5:14 p.m., the Administrator indicated she was not able to provide CPR or First Aid certifications for the staff members on duty for the above mentioned shifts the week of 2/7/24 through 2/13/24. One staff member certified in CPR and First Aid was required to be in the building at all times. The facility lacked staff with active First Aid Certifications. Three staff members had active CPR certifications. The facility followed the Indiana State guidelines regarding CPR and First Aid requirements for staff members.		by the Director of Nursing or designee to ensure that at least one staff member is present in the community with the appropriate certifications. A monthly monitoring schedule will be created as a tool to review any upcoming CPR/First Aid renewals. **How the corrective actions will be monitored to ensure the deficient practice I will not recur?** Work schedules will be audited by the Director of Nursing, Executive Director or designee 5 times weekly for 4 weeks, then 3 times weekly for the following 4 weeks, then 1 time weekly for the following 4 weeks. Date of compliance : 3/15/24	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or			

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	(E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on record review and interview, the facility failed to ensure completion of general orientation and specific orientation, a reviewed and signed job description , and resident rights education upon hire for 1 of 5 employee files reviewed. (CNA 4) Finding includes: CNA 4's employee record was reviewed on 2/14/24 at 2:00 p.m. CNA 4 was hired on 11/1/23. Their personnel file lacked a job description, general and specific job orientation, and resident rights education acknowledgment. Review of the worked schedule on 2/13/24 at 1:34 p.m., indicated CNA 4 worked full time on days shift.	R 0119	R119 **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** A review of all employee files was conducted by the Executive Director to identify any employee lacking the following; appropriate orientation documentation, signed job descriptions and resident rights education. The results of this review were shared with the IDT team, and all department supervisors were reeducated on the orientation process, including appropriate documentation and	03/15/2024

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	During an interview on 2/14/24 at 2:36 p.m., the Administrator indicated resident rights education acknowledgement was required to be completed upon hire and annually, and documented in the personnel file. During an interview on 2/14/24 at 5:14 p.m., the Administrator indicated she had identified employee records concerns when she hired on 1/15/24, but was unable to get it corrected prior to survey entrance conference. She was unable to provide any additional employee records on the above mentioned staff member. A current facility policy, dated 7/30/20, titled "New Hire Policy & Procedures," provided by the Administrator on 2/14/24 at 5:55 p.m., indicated the following: "Policy: The Community is responsible for complying with all applicable laws and Indiana State Department of Health Regulations... Procedures... 6) Business Office Manager [BOM] then has them fill out all additional new hire paperwork as outlined in the New Hire Checklist [Indiana]... 12) The New Employee Hiring Checklist... will be filed in the employee's personnel file and maintained...." A current facility document, last updated 10/2022, titled "New Employee Hiring Checklist (Indiana)," provided by the Administrator on 2/14/24 at 5:55 p.m., indicated the following: "... Documents for Employee's GREEN Personnel File: Job Description Reviewed and Signed by Employee...Resident Rights Acknowledgement Form...."		timeliness. **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?** Any employee record lacking the appropriate orientation documentation, signed job description and/or resident rights education will be updated with the completed documentation. All new hire employee records will be created using the Employee Records state form 5440 as a compliance tool for accuracy. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur** The facility will use the Employee Records state form 5440 as compliance tool for all new hire employee records. New hire orientation schedules will be reviewed by IDT team during morning stand up meetings as needed to ensure all necessary documentation has been completed in the appropriate time frames. Business office personnel responsible for maintaining employee records, along with department supervisors will be educated upon hire on the required orientation requirements. **How the corrective actions will be monitored to ensure the**	

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			deficient practice will not recur? An audit will be conducted weekly of at least 3 employee files for 3 months or until 100% compliance is achieved. Audit to be completed by Executive Director or designee. Date of compliance 3/15/24	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive			

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	reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure physical health screening exams were completed prior to employment to the facility for 4 of 5 employee records reviewed (DON, CNA 4, CNA 5, and CNA 6) and tuberculin skin tests were completed according to facility policy for 2 of 5 employee records reviewed. (DON and CNA 5) Findings include: The employee records were reviewed on 2/14/24 at 2:00 p.m. and indicated the following: The DON's hire dated was 11/6/23. The employee record lacked tuberculin skin tests upon hire and a physical health screening exam. CNA 4's hire date was 11/1/23. The employee record lacked a physical health screening exam. CNA 5's hire date was 11/20/23. The employee record lacked tuberculin skin tests upon hire and a physical health screening exam. CNA 6"s hire date was 1/11/24. The employee record lacked a physical health screening exam.	R 0121	R 121 **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** A review of all current employee personnel records was completed to identify any employee who is lacking physical health screens and/or TB screenings. The results of this review were discussed with IDT team and the policy was reviewed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?** A physical health screen will be completed for any employee identified to be lacking the screen in their personnel file. Any employee identified to be lacking the initial TB skin test will be given a 1st step and 2nd step per	03/15/2024

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	During an interview with the Administrator on 2/14/24 at 2:36 p.m., she indicated the facility did not have records of physical health screenings for the DON, CNA 4, CNA 5, and CNA 6, nor tuberculin skin tests for the DON and CNA 5. During an interview on 2/14/24 at 5:14 p.m., the Administrator indicated she had identified employee records concerns when she hired on 1/15/24, but was unable to get it corrected prior to survey entrance conference. She was unable to provide any additional employee records on the above mentioned staff members. A current facility policy, dated 7/30/20, titled "New Hire Policy & Procedures," provided by the Administrator on 2/14/24 at 5:55 p.m., indicated the following: "Policy: The Community is responsible for complying with all applicable laws and Indiana State Department of Health Regulations... Procedures... 6) Business Office Manager [BOM] then has them fill out all additional new hire paperwork as outlined in the New Hire Checklist [Indiana]... 12) The New Employee Hiring Checklist... will be filed in the employee's personnel file and maintained...." A current facility document, last updated 10/2022, titled "New Employee Hiring Checklist (Indiana)," provided by the Administrator on 2/14/24 at 5:55 p.m., indicated the following: "Pre-Hire Documents for Employee's Confidential RED Personnel File: ...1st Step PPD [tuberculin] Skin Test Results (must be read on or before start date per State Regulations)...Employee Physical... Documents for Employee's Confidential RED Personnel File: ...2nd step PPD Skin Test Results (to be scheduled 1-3 weeks after 1st step is read w/negative results)...."		requirements. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Facility has initiated a partnership with Well Now Urgent Care to complete all new hire physical health screenings. TB screens will be administered at least 48 hours prior to new employee's actual start date and read prior to employee having any resident contact. A binder was created and updated with all current TB screens and annual risk assessments. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** An audit will be conducted weekly of at least 3 employee files for 3 months or until 100% compliance is achieved. The TB binder will be reviewed weekly during morning stand up meeting for 3 months. Date of compliance: 3/15/24	

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	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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