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	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDAR CREEK OF WARSAW	425 CHINWORTH CT WARSAW, IN 46580

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: February 19 & 20, 2025 Facility number: 011389 Residential Census: 20 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 2/24/2025	R 0000		
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review, observation and interview, the facility failed to ensure an emergency information binder was accurate and complete with all required resident information for 14 of 20 residents. Finding includes: The emergency binder for the facility was reviewed on 2/19/2025 at 2:38 P.M. The following items were observed missing: - 14 of 20 face sheets lacked the provider/physician's phone number. During an interview, on 2/19/2025 at 3:08 P.M., the Administrator indicated the emergency binder should have had the phone number of the physician for each resident. On 2/20/2025 at 9:54 A.M., the Administrator	R 0356	**R 356 410 IAC 16.2-5-8.1(i) (1-8) Clinical Records – Noncompliance** **1 What corrective action(s) will be accomplished will be accomplished for those residents found to have been affected by the deficient practice:** An audit took place on 2/21/2025 of the resident emergency files to determine which residents did not have their primary physician number listed on the resident's file. On 2/21/2025 the resident emergency file was updated to ensure the resident's physician phone number was listed on each resident's file. **2 How will the facility**	02/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marcie	Fisher	03/07/2025

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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	indicated the facility did not have a policy regarding the emergency binder, however she indicated the facility followed the state regulations.		**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. As such the DON printed off resident records from the EHR system for all residents to ensure that the record fully encompassed all required information per the Indiana State rule. **3 What measures 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 2/20/2025 on the Indiana State rule regarding what information is required to be in the resident files. DON or designee will ensure that upon admission the resident file has all required information and is printed out and added to the emergency binder upon admission. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recure, i.e.., what quality assurance program will be put into place:** The Executive Director is responsible for sustained compliance. The DON/designee will complete audits of the emergency binder weekly for 4	

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			weeks, biweekly for 4 weeks, and monthly for 1 month to ensure that all required information is present in the resident file for each resident. The audit will be discussed at monthly IDT meetings. The ED will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to provide an annual health statement indicating the residents were free from communicable diseases for 2 of 9 residents reviewed for annual health statements. (Residents 6 & 10) Findings include: 1. A record review for Resident 6 was completed on 2/19/2025 at 11:10 A.M. Diagnoses included, but were not limited to: chronic kidney disease, malignant neoplasm of bladder and diabetes mellitus type 2. A Physician Plan of Care form, dated 1/20/2023, indicated Resident 6 was free of communicable disease. A Physician's Assessment, History & Physical and Certification form was signed by the physician on 10/8/2024. The form and attached physician's note did not include any statement to indicate Resident 6 was free of communicable diseases.	R 0409	**R 409 IAC 16.2-5-12(d) Infection Control – Non-compliance** **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 2/21/2025 of all resident health assessments to identify all residents who did not have a completed health assessment, prior to admission, that included a history of significant past or present infections diseases and a statement that the resident shows no evidence of tuberculosis in an infections stage. Those residents who were identified as not having completed health assessments will have a new health assessment completed by their physician and added to their file upon completion. **2 How the facility will**	02/21/2025

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	During an interview, on 2/20/2025 at 8:32 A.M., the Director of Nursing indicated the corporation felt the annual risk assessment (for tuberculosis symptoms) covered the requirement related to annual health statements. She indicated even though the annual health statement was not completed for Resident 6, she had been assessed by the physician timely. 2. A record review for Resident 10 was completed on 2/19/2025 at 1:28 P.M. Diagnoses included, but were not limited to: anxiety, hypertension, atrial fibrillation and diverticulosis. A Physician's Assessment, History & Physical and Certification form was signed by the physician, on 10/8/2024. The form and attached physician's note did not indicate that Resident 10 was free of communicable diseases. During an interview, on 2/25/2025 at 9:47 A.M., the Director of Nursing indicated the form should have been filled out completely by the physician. On 2/20/2025 at 9:54 A.M., the Executive Director indicated the facility did not have a policy related to completing the annual health statements and the facility followed the state regulations.		**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. As such the DON reviewed all resident health assessments to ensure that the assessments fully encompassed all required information per the Indiana State rule. On 2/27/2025, the ED and DON met with the physician who completed the deficient health assessments to educate him and his office on the Indiana State rule to help ensure future health assessments are in compliance with the Indiana State rule. **3 What measures 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 2/20/2025 on the Indiana State rule regarding what information is required to on the resident health assessment. DON or designee will ensure that upon admission the resident health assessment has all required information. **4 How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e..,**	

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			what quality assurance program will be put into place: The Executive Director is responsible for sustained compliance. The DON/designee will complete audits of the resident health assessments weekly for 4 weeks, biweekly for 4 weeks, and monthly for 1 month to ensure that all required information is present on the resident health assessment for each resident. The audit will be discussed at monthly IDT meetings. The ED will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	