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	03/24/2025

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 a Recertification and State Licensure Survey and Investigation of Complaints IN00453797, IN00455115 and IN00455470. This visit included a State Residential Licensure Survey. Complaint IN00453797 - No deficiencies related to the allegations are cited. Complaint IN00455115 - No deficiencies related to the allegations are cited. Complaint IN00455470 - No deficiencies related to the allegations are cited. Survey dates: March 17, 18, 19, 20, 21 and 24, 2025 Facility number: 013144 Provider number: 155822 AIM number: 201246060 Census Bed Type: SNF/NF: 33 SNF: 22 Residential: 31 Total: 86 Census Payor Type: Medicare: 19 Medicaid: 28 Other: 8 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 3/28/2025	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelly Dyrek	Executive Director	04/10/2025

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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F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances Based on record review and interview, the facility failed to ensure a concern related to missing clothing was documented and investigated for 1 of 1 residents reviewed for grievances. (Resident 6) Finding includes: During an interview on 3/17/25 at 1:28 p.m., Resident 6 indicated she had been missing a baseball sweatshirt for a couple of months and it had never been replaced. She also indicated she had been missing a blue and white nightgown, for approximately the past two weeks, that had not been found or replaced. The resident's record was reviewed on 3/19/25 at 1:20 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypotension and muscle weakness. The Quarterly Minimum Data Set assessment for Resident 6, dated 3/14/25, indicated the resident was cognitively intact and needed substantial assistance for bed mobility and transfers. Resident grievances for the past six months were reviewed. There were no grievances from Resident 6 related to missing clothing. During an interview on 3/19/25 at 11:23 a.m., the Director of Nursing indicated she was aware of the missing items and the sweatshirt had been ordered and they were still looking for the nightgown. She indicated she did not know when the sweatshirt had been ordered or if a grievance had been completed regarding Resident 6's	F 0585	F585 1 Resident 6 affected with no negative outcomes related to missing clothing. 2 All residents have the potential to be affected. Director of social service and or designee will complete a whole house audit on grievances for missing clothing. Designee to in-service all staff regarding the policy on grievances. 3 As a measure of quality assurance, designee will audit all grievances missing clothing were investigated in morning meeting. 4 As a quality measure, designee will review any findings for trends during monthly quality assurance performance improvement meetings for 6 months or until 100% compliance is achieved, plans will be revised as warranted.	04/10/2025

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	missing clothing. During an interview on 3/19/25 at 11:57 a.m., the Executive Director (ED) indicated the Business Office Manager had found out about the missing sweatshirt on Sunday (date not provided) and would be bringing one (a grievance form) to the resident. The ED indicated she had spoken with the resident who indicated she had reported the items as being missing, but no grievance had been completed. The policy, "Resident Concern Process", indicated the following: "...1. The facility will provide an open and customer friendly atmosphere for the residents and their families and representatives to voice concerns and problems with the assurance that their concerns will be heard and acted upon...." and, "...7. Follow up from the department leader will occur within 24-48 hours with resolution entered into KeyStats (electronic charting system)...." 3.1-7(a)(2)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to antidepressants, antibiotics and antianxiety medications for 3 of 18 residents reviewed for assessments. (Residents 48, 41 and 55) Findings include: 1. Resident 48's record was reviewed on 3/18/25 at 11:10 a.m. Diagnoses included, but were not	F 0641	This tag is not in our 2567 for a correction.	04/10/2025

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	limited to, chronic bronchitis, heart failure, anemia and atrial fibrillation. The Admission Minimum Data Set assessment, dated 2/20/25, indicated the resident was cognitively intact and received antianxiety, anticoagulant, antibiotic and diuretic medications. The assessment indicated antidepressant medications were not indicated as being received by Resident 48. A Physician's Order, dated 2/17/25, indicated the resident was to take Trazadone (an antidepressant) 25 milligrams (mg) every night. A Physician's Order, dated 2/17/25, indicated the resident was to take Wellbutrin XL (an antidepressant) 150 mg once daily. During an interview on 3/19/25 at 11:23 a.m., the Director of Nursing (DON) indicated the MDS had been modified to indicate Resident 48 received antidepressants. 2. Resident 41's record was reviewed on 3/19/25 at 11:50 a.m. Diagnoses included, but were not limited to, hypertension, depression, and anxiety disorder. The Admission MDS assessment, dated 3/3/25, indicated the resident had not received any antidepressant medications in the past seven days. A Physician's Order, dated 2/26/25, indicated the resident was to receive sertraline (Zoloft, an antidepressant medication) 50 mg (milligrams) daily. The Medication Administration Records (MARs), dated 2/2025 and 3/2025, indicated the resident had received the sertraline daily.			

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	During an interview on 3/20/25 at 2:23 p.m., the DON indicated the assessment was not correct and would need to be modified.3. The record for Resident 55 was reviewed on 3/20/25 at 3:20 p.m. The resident admitted to the facility on 2/26/25. Diagnoses included, but were not limited to, Parkinson's disease, fracture of first lumbar vertebra, right side rib, and left pubis. The Admission Minimum Data Set (MDS) assessment, dated 3/5/25, indicated the resident was cognitively intact for daily decision making. The assessment indicated Resident 55 had received an antibiotic medication in the last 7 days but did not indicate the resident had received an antianxiety medication during the previous seven days. A Physician's Order, dated 2/26/25, indicated the resident was to receive buspirone (an antianxiety medication) 5 milligrams, 1 tablet twice a day. The February and March 2025 Medication Administration Record (MAR) indicated the resident had received the buspirone as ordered. There were no current or discontinued orders for antibiotic medications. The February and March 2025 MAR indicated the resident had not received any antibiotic medications. During an interview on 3/21/25 at 10:31 a.m., the MDS Coordinator indicated a modification of the MDS would need to be completed. 3.1-31(i)			

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F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to ensure medications were administered and/or held per blood pressure parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 31) Finding includes: Resident 31's record was reviewed on 3/18/25 at 1:52 p.m. Diagnoses included, but were not limited to, Parkinson's disease, chronic kidney disease, and congestive heart failure. The Significant Change in Status Minimum Data Set (MDS) assessment, dated 1/20/25, indicated the resident was moderately cognitively impaired for daily decision making. The current March 2025 Physician Order Summary (POS) indicated the resident was to receive propranolol (high blood pressure treatment) 40 milligrams 1 tablet, hold if heart rate was less than 60 beats per minute and/or systolic blood pressure (top number of blood pressure reading) was less than 120 and hydrochlorothiazide (a diuretic medication) 25 milligrams 1 tablet, hold if systolic blood pressure is less than 120. The February and March 2025 Medication Administration Record (MAR) indicated the propranolol was administered outside of the set parameters on the following dates and times: - 2/5/25 6:00 p.m. to 10:00 p.m. dose: BP (blood pressure) 110/74, HR (heart rate) 60 - 2/14/25 6:00 p.m. to 10:00 p.m. dose: BP 101/46, HR 83 - 2/20/25 6:00 p.m. to 10:00 p.m. dose: BP 104/62,	F 0684	F684 1 Resident 31 was affected with no negative outcomes related to blood pressure medication given out of parameters. 2 All residents with parameters for blood pressure medication have the ability to be affected. DHS and or designee to educate staff on following parameters on blood pressure medication. All medication with blood pressure parameters audited. 3 As a measure of quality assurance, designee will audit 5 medications weekly for 6 months for following blood pressure parameters. 4 As a quality measure, designee will review any findings for trends during monthly quality assurance performance improvement meetings for 6 months or until 100% compliance is achieved, plans will be revised as warranted.	04/10/2025

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	HR 72 - 2/24/25 6:00 p.m. to 10:00 p.m. dose: BP 112/71, HR 54 - 2/27/25 6:00 p.m. to 10:00 p.m. dose: BP 110/64, HR 67 - 3/1/25 6:00 a.m. to 10:00 a.m. dose: BP 105/58, HR 73 The February 2025 MAR indicated the hydrochlorothiazide medication was administered outside of the set parameters on 2/7/25 from 6:00 a.m. to 10:00 a.m. with a BP of 119/68. During an interview on 3/19/25 at 1:23 p.m., the Director of Nursing indicated the medications should have been held per the physician's orders. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review and interview, the facility failed to ensure safety measures were implemented related to a broken wheelchair brake and fall interventions were put into place as ordered for 2 of 4 residents reviewed for falls. (Residents 48 and 55) Findings include: 1. On 3/17/25 at 11:28 a.m., Resident 48 was observed in her room. She indicated she had fallen in the bathroom because her wheelchair was unstable and one of the locks did not work. She indicated she had reported the issue to several people. The wheelchair was present and the right brake was noted to be broken and did not work. Resident 48's record was reviewed on 3/18/25 at	F 0689	F689 1 Residents 48 and 55 were affected with no negative outcomes related to wheelchair brakes not working and fall interventions not in place. 2 All residents have the ability to be affected. DHS and/or designee to educate staff on wheelchair brakes and fall interventions. Audit completed on all wheelchair brakes and fall interventions. 3 As a measure of quality assurance, designee will audit 5 wheelchair brakes and 5 fall interventions weekly. 4 As a quality measure,	04/10/2025

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	11:10 a.m. Diagnoses included, but were not limited to, chronic bronchitis, heart failure, anemia and atrial fibrillation. The Admission Minimum Data Set assessment, dated 2/20/25, indicated the resident was cognitively intact and required substantial assistance for bed mobility and transfers. A Nursing Progress Note, dated 3/13/25, indicated the resident was being transferred from the toilet to the locked wheelchair when she slid from the seat onto the floor. During an interview on 3/18/25 at 11:33 a.m., CNA 1 indicated the right brake on the resident's wheelchair did not work properly and she thought a work order had been placed to have it repaired. During an interview on 3/18/25 at 11:45 a.m., the Executive Director indicated a work order had been placed that morning (3/18/25) to have the wheelchair brake repaired. He indicated the facility had been unaware the wheelchair brake was not working prior to then. 2. During observations on 3/17/25 at 10:42 a.m. and 3/20/25 at 3:08 p.m. there was no sign in Resident 55's bathroom to remind the resident to call for assistance. Resident 55's record was reviewed on 3/20/25 at 3:20 p.m. The diagnoses included, but were not limited to, fracture of first lumbar vertebra, one rib on the right side, and left pubis, and Parkinson's disease. An Admission Minimum Data Set assessment, dated 3/5/25, indicated she was cognitively intact for daily decision making, required maximum assistance with transfers, was dependent for		designee will review any findings for trends during monthly quality assurance performance improvement meetings for 6 months or until 100% compliance is achieved, plans will be revised as warranted.	

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	toileting, and had a fall with a fracture prior to admission into the facility and had had a fall with major injury since her admission to the facility. A Care Plan, dated 2/26/25, indicated the resident was at risk for falls related to a history of falls with lumbar and rib fractures and a recent left pubis fracture. The interventions included, but were not limited to the following: a sign in the bathroom to remind the resident to call for assistance, therapy to evaluate and treat, staff to assist the resident with transfers as needed and to keep the call light within the resident's reach. During an interview on 3/20/25 at 3:56 p.m., the Director of Nursing indicated the resident frequently removed signs placed in her room because she did not believe she needed help from the staff. A policy titled, "Fall Management Program Guidelines," indicated "...2. Should the resident experience a fall the attending nurse shall complete the 'Fall Event.' This includes an investigation of the circumstances surround the fall to determine the cause of the episode...interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness..." 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review, the facility failed to ensure an indwelling Foley (urinary) catheter collection bag was kept off of the floor and documentation of urinary output was completed for 1 of 1 resident reviewed	F 0690	F690 1 Resident 3 was affected with no negative outcomes related to foley catheter bag on floor and urine output not completed.	04/10/2025

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	for urinary catheters. (Resident 3) Finding includes: On 3/20/25 at 10:42 a.m. and 12:00 p.m. Resident 3 was observed in her wheelchair. The catheter collection bag was noted to be on the floor under the chair. Record review for Resident 3 was completed on 2/21/25 at 9:46 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of bladder, urinary retention, and personal history of urinary tract infections. The Quarterly Minimum Data Set (MDS) assessment, dated 1/29/25, indicated the resident was severely cognitively impaired and had an indwelling urinary catheter. The March 2025 Physician's Order Summary, indicated an order for the resident to have an indwelling urinary catheter and to perform catheter care every shift. The current care plans, indicated the resident used a Foley (urinary) catheter for diagnosis of neurogenic bladder. Interventions included, but were not limited to, record resident urinary output, keep leg strap in place, maintain a closed system with urinary bag below the bladder and cover. The urinary output vitals documentation reviewed from 1/20/25-3/20/25 indicated on the following dates, output was noted as small, medium, or large instead of an accurate amount of milliliters of urine: - Small: 2/19 at 10:42 a.m., 2/22 at 12:56 p.m., 2/23 at 1:52 p.m., 2/27 at 10:50 a.m., 2/27 at 1:07 p.m., 2/28 at 8:45 a.m., 2/28 at 1:07 p.m., 3/4 at 10:44 a.m., 3/6		2 All residents who have foley catheters have the ability to be affected. DHS and/or designee to educate staff on foley catheters not on the floor and urinary output being measured. Whole house audit completed on residents who have foley catheters. 3 As a measure of quality assurance, designee will audit 5 residents a week with foley catheters for not on floor and output measured. 4 As a quality measure, designee will review any findings for trends during monthly quality assurance performance improvement meetings for 6 months or until 100% compliance is achieved, plans will be revised as warranted.	

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	at 1:16 p.m., 3/8 at 10:26 a.m., 3/13 at 10:32 a.m., 03/13 at 11:25 a.m., 03/14 at 11:41 a.m., and 3/18/25 at 11:13 a.m. - Medium: 1/20 at 2:53 p.m., 1/22 at 5:37 a.m., 1/22 at 1:57 p.m.,1/25 at 1:54 p.m., 1/27 at 10:23 p.m., 2/4 at 10:58 a.m., 2/4 at 1:55 p.m., 2/5 at 1:42 p.m., 2/6 at 10:51 a.m., 2/7 at 11:35 p.m., 2/8 at 11:07 a.m., and 2/11/25 at 11:24 a.m. - Large: 1/22 at 10:49 a.m., 1/23 at 10:39 a.m., 1/23 at 11:10 a.m., 1/23 at 1:44 p.m., 1/25 at 12:10 p.m., 1/26 at 11:35 a.m., 1/26 at 2:25 p.m., 1/28 at 11:33 a.m., 1/28 at 2:14 p.m., 1/30 at 11:17 a.m., 1/31 at 10:29 a.m., 2/5 at 8:13 a.m., 2/6 at 1:21 p.m., 2/8 at 1:24 p.m., 2/9 at 10:13 a.m., and 2/9/25 at 1:06 p.m. During an interview on 3/20/25 at 2:22 p.m., the Director Of Nursing (DON) indicated the facility did not have a specific policy related to documentation of urinary output for residents that have catheters and she indicated there was no further information to provide. 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview, the facility failed to ensure a resident received the necessary care and treatment related to oxygen flow rate for 1 of 1 residents reviewed for respiratory care. (Resident 16) Finding includes: On 3/18/25 at 9:37 a.m., Resident 16 was observed seated in her room. Her portable oxygen was in use and the flow meter was set on 2 liters per	F 0695	F695 1 Resident 16 was affected with no negative outcomes related to incorrect oxygen flow rate. 2 All residents on oxygen have the ability to be affected. DHS and/or designee to educate staff on correct oxygen flow rate. Residents on oxygen audited for correct flow rate. 3 As a measure of quality	04/10/2025

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	minute (LPM). The resident's record was reviewed on 3/18/25 at 2:10 p.m. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia and metabolic encephalopathy. The Quarterly Minimum Data Set assessment, dated 1/14/25, indicated the resident was moderately cognitively impaired, used oxygen and was dependent on staff for toileting and transfer needs. A Physician's Order, dated 9/17/24 indicated the resident was to have oxygen administered at 4 lpm by nasal cannula continuously. On 3/18/25 at 11:43 a.m., the resident was observed again in her room with the oxygen flowing at 2 lpm. LPN 1 was present and indicated it should have been set on 4 lpm. She adjusted it to the correct flow rate at that time. 3.1-47(a)(6)		assurance, designee will audit 5 residents with oxygen weekly for correct flow rate. 4 As a quality measure, designee will review any findings for trends during monthly quality assurance performance improvement meetings for 6 months or until 100% compliance is achieved, plans will be revised as warranted.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to ensure a pain medication was not administered prior to non-pharmacological interventions and pain monitoring completed for 1 of 5 residents reviewed for unnecessary medications. (Resident 48) Finding includes: Resident 48's record was reviewed on 3/18/25 at 11:10 a.m. Diagnoses included, but were not	F 0757	F757 1 Resident 48 was affected with no negative outcome related to non-pharmacological interventions and pain monitoring completed. 2 All residents who have as needed pain medication have the ability to be affected. DHS and/or designee will educate staff on prior non-pharmacological interventions and pain monitoring. Designee to	04/10/2025

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	03/24/2025

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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	limited to, chronic bronchitis, heart failure, anemia and atrial fibrillation. The Admission Minimum Data Set assessment, dated 2/20/25, indicated the resident was cognitively intac and required substantial assistance for bed mobility and transfers. A Physician's Order, dated 2/13/25, indicated to give acetaminophen 650 milligrams every six hours as needed for pain. The March 2025 Medication Administration Record indicated the resident received acetaminophen 15 times between 3/1-3/18/25. There was no documentation to indicate where the pain was located, what the severity of the pain was or any non-pharmacological interventions that had been attempted prior to administering the medication. A current Pain Care Plan, dated 2/14/25, indicated the resident was at risk for pain. Interventions included, but were not limited to, attempt non-pharmacological interventions and observe for and record verbal and non-verbal signs of pain. During an interview on 3/19/25 at 10:22 a.m., the Director of Nursing indicated there should have been a pain level documented, site description of pain documented and prior interventions documented prior to administering the pain medication. 3.1-48(a)(4)		audit all residents who have as needed pain medication for prior non-pharmacologic interventions and pain monitoring. 3 As a measure of quality assurance, designee will audit 5 residents weekly for prior non-pharmacologic interventions and pain monitoring completed. 4 As a quality measure, designee will review any findings for trends during monthly quality assurance performance improvement meetings for 6 months or until 100% compliance is achieved, plans will be revised as warranted.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use			

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	155822	A. BUILDING 00 B. WING	03/24/2025

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CEDAR CREEK HEALTH CAMPUS	18275 BURR STREET LOWELL, IN 46356

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	Based on record review and interview, the facility failed to ensure a prn (as needed) antianxiety medication was evaluated for continued use every 14 days for 1 of 5 residents reviewed for unnecessary medications. (Resident 48) Finding includes: Resident 48's record was reviewed on 3/18/25 at 11:10 a.m. Diagnoses included, but were not limited to, chronic bronchitis, heart failure, anemia and atrial fibrillation. The Admission Minimum Data Set assessment, dated 2/20/25, indicated the resident was cognitively intact, required substantial assistance for bed mobility and transfers and took antianxiety medication. A Physician's Order, dated 2/13/25, indicated to give alprazolam (an antianxiety medication) 0.5 milligrams nightly prn. There was no stop date on the order. There was another Physician's Order, dated 3/17/25, to give alprazolam 0.5 milligrams nightly prn. During an interview on 3/19/25 at 11:23 a.m., the Director of Nursing indicated there had not been a 14-day stop date on the original order. 3.1-48(a)(2)	F 0758	F758 1 Resident 48 was affected with no negative outcome related to continued use of an antianxiety medication after 14 days. 2 All residents who have as needed antianxiety medication have the ability to be affected. DHS and/or designee will educate staff on 14 day stop date. Designee to audit all residents who have as needed antianxiety medication for 14 day stop date. 3 As a measure of quality assurance, designee will audit 5 residents weekly for 14 day stop date. 4 As a quality measure, designee will review any findings for trends during monthly quality assurance performance improvement meetings for 6 months or until 100% compliance is achieved, plans will be revised as warranted.	04/10/2025
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to ensure infection control guidelines were in place and implemented	F 0880	F880 1 Resident 56 was affected with no negative outcomes related	04/10/2025

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	related to Enhanced Barrier Precautions for 1 of 1 residents reviewed for isolation. (Resident 56) Finding includes: On 3/17/25 at 11:42 a.m. and 3/21/25 at 11:07 a.m., Resident 56's room was observed. There were no signs on the door or nearby indicating the resident was in Enhanced Barrier Precautions. There were no personal protective equipment (PPE) bins near the room door or inside the room. Resident 56's record was reviewed on 3/21/25 at 2:03 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing) and dementia. The Admission Minimum Data Set (MDS) assessment, dated 1/22/25, indicated the resident was severely cognitively impaired and required a feeding tube. A Physician's Order, dated 1/17/25, indicated the resident was on Enhanced Barrier Precautions and the staff were to wear a gown and gloves at minimum during high-contact care activities. During an interview on 3/24/25 at 1:21 p.m., the Director of Nursing indicated the sign had just fallen down and she planned on finding another way to adhere it near the doorway. 3.1-18(b)		to no enhanced barrier precaution sign. 2 All residents who need enhanced barrier precautions have the ability to be affected. DHS and/or designee to educate staff on enhanced barrier precautions. Designee to audit all residents for the need for enhanced barrier precautions. 3 As a measure of quality assurance, designee will audit 5 residents weekly for the need for enhanced barrier precautions. 4 As a quality measure, designee will review any findings for trends during monthly quality assurance performance improvement meetings for 6 months or until 100% compliance is achieved, plans will be revised as warranted.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and	R 0000	The submission of this plan of correction does not indicate an admission by Cedar Creek Health	

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	State Licensure Survey and the Investigation of Nursing Home Complaints IN00453797, IN00455115 and IN00455470. Complaint IN00453797 - No deficiencies related to the allegations are cited. Complaint IN00455115 - No deficiencies related to the allegations are cited. Complaint IN00455470 - No deficiencies related to the allegations are cited. Survey dates: March 17, 18, 19, 20, 21 and 24, 2025 Facility number: 013144 Residential Census: 31 Cedar Creek Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality Review completed on 3/24/2025		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.	