DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	05/22/2023

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. This visit included a State Residential Licensure Survey. Survey dates: May 15, 16, 17, 18, 19 and 22, 2023. Facility number: 013144 Provider number: 155822 AIM number: 201246060 Census Bed Type: SNF/NF: 32 SNF: 20 Residential: 31 Total: 83 Census Payor Type: Medicare: 9 Medicaid: 28 Other: 15 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/25/23.	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 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed related to	F 0641	MDS's were corrected on 5/17/2023 and resubmitted.	05/23/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judy Plantinga	Executive Director	06/12/2023

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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	antipsychotic medication and insulin use for 2 of 17 MDS assessments reviewed. (Residents 24 and 30) Findings include: 1. The record for Resident 24 was reviewed on 5/15/23 at 10:29 a.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, and Parkinson's Disease. The Quarterly MDS assessment, dated 4/11/23, indicated the resident had received antipsychotic medication in the past seven days. The 3/2023 and 4/2023 Medication Administration Records (MAR) lacked any documentation of administration of an antipsychotic medication. Interview with the MDS Nurse on 5/16/23 at 3:03 p.m., indicated the MDS was incorrect, there was no antipsychotic medication given. She would make a correction. 2. The record for Resident 30 was reviewed on 5/16/23 at 10:30 a.m. Diagnoses included, but were not limited to, hypertension, anxiety disorder, and depression. The Quarterly MDS assessment, dated 3/9/23, indicated the resident had received an insulin injection in the past seven days. The 2/2023 and 3/2023 Medication Administration Records (MAR) lacked any documentation of administration of an insulin injection. Interview with the MDS Nurse on 5/16/23 at 3:03 p.m., indicated the MDS was incorrect, there was no insulin injection given. She would make a			

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	correction. 3.1-31(i)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure dependent residents received the necessary care for activities of daily living care (ADL) related to not receiving showers as scheduled and not receiving timely assistance to a call light for 2 of 4 residents reviewed for ADL care. (Residents 160 and 259) Findings include: 1. On 5/15/23 at 1:38 p.m., Resident 160 was sitting in a wheelchair in her room. The resident indicated she had been at the facility for a week and just finally received a shower that morning. Record review for Resident 160 was completed on 5/17/23 at 12:57 p.m. Diagnoses included, but were not limited to, right humerus fracture, anxiety, and depression. The resident was admitted to the facility on 5/8/23. A Life Enrichment Assessment, dated 5/10/23, indicated it was very important to the resident for bathing and preferred showers. The Bathing Task record indicated the resident had received one shower since admission date of 5/8/23. The resident received a shower on 5/15/23 Interview with the Director of Health Services	F 0677	1. Resident 259 was affected by alleged deficient practice related to call light wait times. Resident was immediately assisted by nurse. Resident was also assessed with no concerns noted. Resident 160 was affected by alleged deficient practice related to showers not being completed. Resident has had all showers on her preferred shower day since alleged deficiency practice. 2. All residents have the potential to be affected. All staff have been educated on the policy related to Guidelines for Answering Call Lights. Nursing staff educated to follow up with residents if they refuse care and to notify nurse/supervisor. Refusals to be documented in resident's chart. 3. Director of Health Services (DHS) or designee will audit call light wait times for 3 residents weekly x 6 weeks, then 3	06/08/2023

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	(DHS) on 5/17/23 at 1:23 p.m., indicated the resident should have received a shower prior to 5/15/23. If the resident had refused any showers before then, the staff should have documented the refusal and reapproached her. 2. On 5/22/23 at 9:33, the 100 hallway was observed. There were 2 call lights activated on arrival, Resident 259's bathroom call light was on. The Director of Therapy entered the hall and left. Activity Aide 1 (AA 1) entered the hall and left. Both call lights were still activated. There was no additional staff observed in the hallway. At 9:42 a.m., Resident 259 was heard yelling for help. The resident was in the bathroom on the toilet. There were signs on the wall indicating to call for assistance when transferring. The resident continued to yell out for help. At 9:49 a.m., the Nurse Consultant was notified the resident needed assistance. The resident's record was reviewed on 5/17/23 at 8:50 a.m. The resident was admitted on 5/10/23. Diagnoses included, but were not limited to, L3 and L5 compression fractures, cardiomyopathy and chronic obstructive pulmonary disease with dependence on oxygen. The Brief Interview for Mental Status 5 day assessment, dated 5/16/23, indicated the resident had significant cognitive deficits. A Geriatric Medicine Progress Noted, dated 5/16/23, indicated the resident was alert and oriented to person, place and time, and able to make her needs known. The current Falls Care Plan indicated the resident was at risk for falls related to a history of falls.		residents every other week x 6 weeks, then 3 residents monthly x 3 months. DHS or designee will audit that residents who refused showers are followed up the next day during CCM (Clinical Care Meeting) 2x weekly x 4 weeks, then weekly x 4 weeks, then every other week x 4 weeks then monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at monthly QAPI meeting and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if needed until 100% compliance met.	

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	Interventions included for staff to assist the resident with transfers as needed. The resident was interviewed on 5/22/23 at 2:00 p.m. She was alert and oriented and answered all screening questions appropriately. She indicated this morning was the longest she had waited for assistance in the bathroom, and was feeling desperate so she began to yell for help. She indicated it had been 45 minutes. She also indicated she had fractures in her back, and it was painful to sit up. Interview with the Director of Nursing, on 5/19/23 at 2:03 p.m., indicated the resident was having hallucinations on admission. She indicated the hallucinations were now gone. Interview with AA 1 on 5/22/23 at 2:24 p.m., indicated activity aides were supposed to answer call lights. He did not recall being on the 100 hallway that morning or seeing the call lights activated. Interview with the Nurse Consultant on 5/22/23, indicated she had assisted the resident that morning after being notified she needed assistance. There were four call lights activated on the hall at that time. She was unable to access call light logs to see how long the call light had been activated. 3.1-38(a)(2)(A)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 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			

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	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.			
	Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 1 of 3 residents reviewed for non-pressure related skin conditions. (Resident 19) Finding includes: On 5/15/23 at 10:32 a.m., Resident 19 was observed sitting in a wheelchair in her room. The resident had dark purple discolorations observed to the top of her right wrist and the top of her left hand. The resident indicated her hands get rubbed on the inside of her shirts when the staff assisted her in changing her clothes. On 5/17/23 at 1:36 p.m., Resident 19 was observed sitting in a wheelchair in her room. The same discolorations were still observed. Record review for Resident 18 was completed on 5/17/23 at 11:11 a.m. Diagnoses included, but were not limited to, heart failure, and hypertension. The Annual Minimum Data Set (MDS) assessment, dated 2/20/23, indicated the resident was cognitively intact. The resident required an extensive 2+ person assist with bed mobility and toilet use. A total 2+ assist with transfers, and a total 1 person assist with dressing and personal hygiene. The resident had received an	F 0684	1. Resident 19 was affected by alleged deficient practice. Resident immediately assessed by licensed nurse and bruise was assessed and documented. Resident continues with daily activities per her norm. Family and physician were notified. 2. All residents who receive anticoagulant therapies have the potential to be affected. All nurses were educated on the policy related to weekly skin assessments. Nurse leadership team to complete skin assessments for any residents who are currently taking an anticoagulant with special attention to bruising. 3. DHS or designee to complete skin assessment on 2 residents on anticoagulant therapy to monitor for any bruising weekly x 4 weeks, every other week x 8 weeks and monthly x 3 months. 4. . As a quality measure, the DHS or designee will review any findings and corrective action at monthly QAPI meeting and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as	06/08/2023

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	anticoagulant (blood thinning) medication. A Care Plan, dated 3/7/22 and revised 5/14/23, indicated the resident was at risk for excessive bleeding and bruising related to medications. An intervention included to monitor for excessive bleeding and or bruising. The May 2023 Physician's Order Summary (POS), indicated an order for warfarin (anticoagulant) 2 mg (milligrams) every day. The last Weekly Skin Assessment, dated 5/11/23, indicated old impairment. There was no documentation as to what the old impairment was. There was no documentation to indicate the resident's discolorations had been assessed or were being monitored. Interview with the Director of Health Services (DHS) on 5/19/23 at 1:44 p.m., indicated she was unsure what old impairment the nurse had assessed on the last skin assessment. She could not find any documentation the discolorations had been assessed or were being monitored. 3.1-37(a)		warranted. Ongoing monitoring will continue past 6 months if needed until 100% compliance met.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices			

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	to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure safe water temperatures were maintained for 1 of the 24 rooms observed. This had the potential to affect 1 residents who resided in the room. (Resident 19) Finding includes: During the initial pool process on 5/15/23 at 10:35 a.m., the hot water temperature in Resident 19's felt excessively hot. There was one resident who resided in the room. During an observation with the Director of Plant Operations (DPO) on 5/15/23 at 10:38 a.m., he completed a temperature reading on the hot water in Resident 19's room. The thermometer read 121 degrees Fahrenheit. During an interview at that time, the DPO indicated the hot water temperatures were checked in random rooms daily. The water temperatures should have been 120 degrees Fahrenheit or less. He would turn the water heater down immediately and check other rooms. There had not been any injuries or complaints related to the hot water temperature. A Facility policy titled, "Water Temperature Testing Life Safety", and received as current from the Administrator on 5/17/23, indicated, "Required Water Temperatures:"..."Patient room temperatures are specified by state requirements."..."Indiana 100 -120 degrees Fahrenheit..." 3.1-45(a)(1)	F 0689	1. Resident 19 was affected by the alleged deficient practice. The Director of Plant Operations (DPO) adjusted the mixing valve and rechecked water temps in this room and other rooms on hall with no further concerns noted. 2. All residents on Halstead Hall (200 hall) have the potential to be affected by the alleged deficient practice. DPO checks and logs water temps daily per policy. DPO will adjust valve as needed to maintain water temperatures in acceptable ranges. 3. DPO or designee will increase water temperature checks to 8 rooms per day (2 rooms per hall), daily x 2 months, then 4 rooms per day (1 room per hall) daily x 2 months, then resume required temperature monitoring per policy. 4. As a quality measure, the DHS or designee will review any findings and corrective action at monthly QAPI meeting and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if needed until 100% compliance met.	06/08/2023

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			
	Based on observation, record review, and interview, the facility failed to ensure a resident received proper care and treatment related to oxygen administration flow rate for 1 of 1 residents reviewed for oxygen. (Resident 161) Finding includes: On 5/15/23 at 2:57 p.m., Resident 161 was observed lying in bed. The resident was wearing oxygen via a nasal cannula with a flow rate set at 5 liters. On 5/16/23 at 10:04 a.m., Resident 161 was observed lying in bed. The resident was wearing oxygen via a nasal cannula with a flow rate set at 5 liters. Record review for Resident 161 was completed on 5/16/23 at 1:29 p.m. Diagnoses included, but were not limited to, Guillain-Barre syndrome, quadriplegia, and chronic obstructive pulmonary disease (COPD). A Care Plan, dated 5/12/23, indicated the resident had a potential for shortness of breath while lying flat related to: COPD, and quadriplegia. An	F 0695	1. Resident 161 was affected by deficient practice. DHS noted incorrect oxygen flow rate and corrected immediately. Resident was assessed with no concerns observed. Physician was notified of incident with no new orders. 2. All residents who receive oxygen have the potential to be affected. All nurses were educated on oxygen administration. 3. DHS or designee to complete audit on 3 residents to ensure that oxygen is being administered per physician order 2x weekly x 4 weeks, weekly x 4 weeks, every other week x 4 weeks and monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at monthly QAPI meeting and ongoing until campus achieves 100% compliance in the campus	06/08/2023

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	intervention included to administer oxygen per the physician's order and as needed. The May 2023 Physician's Order Summary (POS) indicated an order for oxygen at 2 liters per nasal cannula continuous. Interview with the Director of Health Services (DHS) on 5/17/23 at 11:53 a.m., indicated the resident's oxygen should have been set at 2 liters and not 5 liters. 3.1-47(a)(6)		Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if needed until 100% compliance met.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview the facility failed to ensure a medication error rate of less than 5% for 2 of 5 residents observed during 5 medication pass observations. 2 errors in medications were observed during 29 opportunities for errors in medication administration. This resulted in a medication error rate of 6.9%. (Residents 42 & 161) Findings include: 1. On 5/17/23 at 4:03 p.m., RN 1 was observed administering Resident 42's medication of ferrous sulfate (iron) 300 mg (milligrams)/ ml (milliliter) via peg tube (a tube inserted into the stomach for feeding & medications). He flushed with 5 ml of water and then proceeded to administer the medication.	F 0759	1. Resident 42 was affected by alleged deficient practice. Physician was notified of flush error with no new orders given. Resident was assessed by licensed nurse with no concerns noted. Resident 161 was affected by the alleged deficient practice. Physician was notified of flush error with no new orders given. Resident was assessed by licensed nurse with no concerns noted. 2. All residents with g-tube flush orders or IV medications have the potential to be affected. Nurse who completed error was immediately educated on G-tube	06/08/2023

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	Record review for Resident 42 was completed on 5/17/23 at 3:59 p.m. The May 2023 Physician's Order Summary (POS) indicated to flush the peg tube with 30 ml of water before and after medication pass. Interview with RN 1 on 5/17/23 at 4:07 p.m., indicated he was unaware of the administration order to flush the peg tube with 30 ml before and after a medication pass and he should he have read the administration order. An Enteral Tube Medication policy, dated 11/2018 received from the Nurse Consultant as current, indicated to, " ...place 15 ml or prescribed amount of warm or sterile water in syringe and flush tubing using gravity" ... 2. On 5/19/23 at 9:40 a.m., RN 1 was observed preparing to administer Resident 161's medication of cefazolin (antibiotic) 2 g (grams)/100 ml (milliliters) via PICC (peripherally inserted central catheter) line. RN 1 flushed the IV line with 10 ml of normal saline and then proceeded to administer the medication. Record review for Resident 161 was completed on 5/19/23 at 10:40 a.m. The May 2023 Physician Order Summary (POS) indicated to flush the PICC line with 5 ml of normal saline before and after medication. Interview with RN 1 on 5/19/23 at 10:41 a.m., indicated he incorrectly flushed the PICC line before the medication with 10 ml of saline instead of the 5 ml that was ordered. 3.1-48(c)(1)		administration and IV flushes. Nurses were educated on the 5 rights of medication administration, G-tube flush policy and IV flush policy. 3. DHS or designee will complete audit to observe medication administration with 2 nurses during medication pass for 1 resident with either a G-tube or IV medication 2x weekly x 4 weeks, weekly x 4 weeks, every other week x 4 weeks and monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at monthly QAPI meeting and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if needed until 100% compliance met.	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record review, the facility failed to ensure medications were labeled correctly related to a bag of individual liquid medications for a resident observed during medication administration. (Resident 42) Finding includes: On 5/17/23 at 4:00 p.m., RN 1 was preparing medication for Resident 42. He pulled out a bag	F 0761	1. Resident 42 was affected by the alleged deficient practice. Nurse immediately labeled bag that resident's medication was in. Resident had no negative outcomes. 2. All residents have the potential to be affected. Nurse was immediately educated on medication label policy. All nurses	06/08/2023

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	155822	A. BUILDING 00 B. WING	05/22/2023

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	with multiple containers of liquid ferrous sulfate (iron) medication. The bag was a clear bag with no label. The individual medication containers only had the name and strength of the medication. Neither the medication containers nor the bag had the resident's name or administration orders. Interview with RN 1 on 5/17/23 at 4:02 p.m., indicated there was no label on the bag with the resident's information and there should have been. A facility policy titled, "Medication Labels" and received as current indicated, " ...labels are permanently affixed to the outside container. No medication is accepted with the label inserted into a vial. If a label does not fit directly onto the product, e.g., eye drops, the label may be affixed to an outside container or carton, but the resident's name, at least, must be maintained directly on the actual product container ...." 3.1-25(j)(1)		were educated on the medication label policy. 100% audit of medication carts completed with no further concerns noted. 3. DHS or designee to complete audit on 1 medication cart to observe that medications are properly labeled per policy weekly x 6 weeks, every other week x 6 weeks, then monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at monthly QAPI meeting and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if needed until 100% compliance met.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to			

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	applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation and interview, the facility failed to ensure food was stored and distributed in a sanitary manner related to an uncovered ice bowl in the main dining room. This had the potential to affect all 52 residents in the facility who received beverages with ice from the main dining room. Finding includes: On 5/16/23 at 3:05 p.m., the ice machine in the main dining room was observed. There was a note taped to the ice dispenser that indicated to use the ice in the bowl on the counter. Observed on the counter was an uncovered stainless steel bowl of ice with the ice scoop laying directly on top of the ice. Staff and residents were scooping ice into glasses. The ice bowl was also accessible to any visitors. Interview with the Executive Director on 5/16/23 at 3:13 p.m., indicated the ice machine had been broken for a month and the part was on backorder. She understood the concern with the communal uncovered ice with the scoop in it.	F 0812	1. No residents were affected by the alleged deficient practice. Bowl of ice was removed from dining area. Ice machine was ordered and will be installed. Director of Food Services (DFS) was immediately educated on food storage policy. 2. All residents have the potential to be affected by the alleged deficient practice. All dietary staff were educated on the food storage policy. 3. DFS or designee will complete audit daily to ensure that any ice is properly covered until ice machine is able to be installed on or before 6/13/23.. DFS will add to audit to observe that ice scoop is not placed in ice bowl. 4. As a quality measure, the DHS or designee will review any findings and corrective action at	06/08/2023

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	3.1-21(i)(3)		monthly QAPI meeting and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months if needed until 100% compliance met.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 15, 16, 17, 18, 19 and 22, 2023. 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 5/25/23.	R 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	

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			department a desk review for substantial compliance.	