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	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDAR CREEK OF BLOOMINGTON MEMORY CARE	3203 MOORES PIKE ROAD BLOOMINGTON, IN 47401

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00435341 and IN00435615. Complaint IN00435341 - No deficiencies related to the allegations are cited. Complaint IN00435615 - State deficiencies related to the allegation are cited at R0036. Survey date: June 20, 2024 Facility number: 012706 Residential Census: 37 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed June 25, 2024.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review the facility failed to notify the physician for a resident that had a fall. (Resident B) Finding includes:	R 0036	**Plan of Correction Cedar Creek Bloomington Memory Care Provider # 012706**	07/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	During an interview on 6/20/24 at 12:28 p.m., CNA 1 indicated on 5/22/24 at approximately 8:00 p.m., CNA 1 was attempting to transfer Resident B when CNA 1 lost her balance and fell backward. Resident B fell with CNA 1 and when they landed Resident B was on top of CNA 1. CNA 1 got up, picked up Resident B, and put Resident B in bed. CNA 1 should have notified the supervisor when the fall occurred. During an interview on 6/20/24 9:43 a.m., the Administrator indicated CNA 1 was terminated for not reporting a fall that occurred, on 5/22/24 at approximately 8:00 p.m. CNA 1 was attempting to transfer Resident B from a Broda chair to her bed. CNA 1 lifted Resident B, lost her balance and fell backward with Resident B. CNA 1 landed on her back and Resident B landed on top of CNA 1. CNA 1 got up, picked up Resident B, and put Resident B in bed. CNA 1 did not report the fall to anyone. The clinical record for Resident B was reviewed, on 6/20/24 at 11:18 a.m. The diagnoses included, but were not limited to, Alzheimer's dementia, senile degeneration of the brain, and multiple sclerosis. An Incident report, dated 5/23/24 at 4:48 p.m., indicated, on 5/22/24 at 8:00 p.m., Resident B was being transferred from her Broda chair to bed by CNA 1. CNA 1 lost her balance and fell to the floor during the transfer, which resulted in Resident B also falling to the floor. Resident B was non-verbal secondary to end state dementia. There were no witnesses to the fall. CNA 1 failed to inform nightshift supervisor of the occurrence. A counseling documentation form, dated 6/7/24,		*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.* Investigation of Complaints IN00435341 and IN00435615. Complaint IN00435341 - No deficiencies related to the allegations are cited. Complaint IN00435615 - State deficiencies related to the allegation are cited at R0036. Survey date: June 20, 2024 Facility number: 012706	

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	indicated CNA 1 was in the process of transferring Resident B from a Broda chair to Resident B's bed. During the transfer Resident B fell. CNA 1 did not report the fall to the QMA. CNA 1 failed to report the fall which is a violation of the workplace conduct. CNA 1's employment was terminated immediately due to violation of facility policy and procedure. On 6/20/24 at 9:40 a.m., the Administrator provided a copy of an undated facility policy, titled Fall Risk Policy and Procedures, and indicated this was the current policy used by the faciity. A review of the policy indicated when a resident falls, notify the physician. This State tag relates to Complaint IN00435615.		**R 036 410 IAC 16.2-5-1.2(k) (1-2) Residents' Rights-Deficiency** (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. **1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Executive Director (ED) and Director of Nursing (DON) completed re-education on 5/29 & 7/3 regarding Cedarhurst communication expectation policy and procedures and Indiana State Department of Health long term care abuse and incident reporting policy to include any event or suspected event that occurs in the community will be	

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			reported to the ED and DON immediately so an investigation can be completed as per Cedarhurst policy and State regulations. **2. 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:** All residents had the potential to be affected by this deficient practice. The Executive Director (ED) and Director of Nursing (DON) completed re-education on 5/29 & 7/3 regarding Cedarhurst communication expectation policy and procedures and Indiana State Department of Health long term care abuse and incident reporting policy, to include any event or suspected event that occurs in the community will be reported to the ED and DON immediately so an investigation can be completed as per Cedarhurst policy and State regulations. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** Current staff will complete	

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			re-education on both the IDOH and Cedarhurst policies and procedures for reporting all alleged or suspected unusual occurrences. New staff will be trained upon hire to ensure competency of incident reporting and communication policy. DON and ED will review any unusual or alleged unusual events during the weekly ROAR communication meeting to ensure there are no new incidents in the community that need investigated and/or reported. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director is responsible for sustained compliance. Residents will be discussed at the weekly ROAR (Resident Opportunity at Risk) meeting. This will help with early identification of residents at risk and trigger the necessary follow-up measures which could include meetings with families, notifications to physicians, investigations, and incident reporting if warranted. This meeting will be held weekly by the Executive Director/designee and	

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			DON/designee. The Executive Director and Business Office Manager will audit all new hire orientations weekly to ensure training on reportable events is completed. Monitoring will be ongoing. **5. By what date will the systemic changes be completed?** July 12, 2024	