STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155796	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedars The	14409 Sunrise CT Leo, IN 46765

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147 Based on interview and record review, the facility failed to conduct a thorough investigation of an allegation of physical abuse for 1 of 3 residents reviewed for abuse (Resident N). Findings include: An incident reported to the Indiana Department of Health, dated 7/30/24, indicated Resident N had complained of severe lower back pain while being provided care by 2 staff members. The resident alleged she had been moved forcefully by the staff and had heard a snap in her back followed by severe pain. She was hospitalized on [DATE] due to the pain. A CAT (a radiology exam) scan completed at the hospital indicated she had an acute compression fracture of her lumbar vertebrae (L3/L4), which required treatment. On 8/16/24 at 1:28 P.M., Resident N's record was reviewed. Diagnoses included paraplegia (paralysis of legs and lower body) due to a progressive neurological disease, diabetes, and weakness. A significant change MDS (Minimum Data Set) assessment, dated 5/1/24, indicated the resident had no cognitive impairment, no moods, behaviors or rejection of care. She had impaired range of motion (ROM) to both her upper and lower extremities and was dependent on staff for toileting, bathing, bed mobility, transfers, and lower body dressing. She required maximal assistance with upper body dressing and personal hygiene. A hospital note, dated 7/30/24, indicated the resident had been hospitalized for increased pain following allegation of staff forcefully transferring her into a wheelchair. She had a mild L3/L4 compression fracture which was treated with vertebroplasty (injection of cement into the fractured vertebrae). A grievance for complaint of care, dated 7/31/24 at 1:00 p.m., indicated Resident N had returned from the hospital and had concerns about her care. She indicated she'd been hospitalized due to a fracture in her back which she alleged occurred due to 2 CNA's (Certified Nurse Aid) moving her back too quickly and hurting her while positioning her in the wheelchair. When asked, the resident indicated she believed it occurred within 24 hours of having the back x-ray ordered. When it occurred, she'd heard her spine crack and had yelled out in pain loudly. She indicated she had reported the incident and increased pain to her nurse within 24 hours and had informed the DON, face to face on 7/26/24. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/24 at 10:55 A.M., Resident N was interviewed. She was observed seated in her oversized recliner chair in her room. When asked, she indicated she couldn't remember who the staff were who provided care when she hurt her back. She wasn't sure if it was agency staff or facility staff, but she fractured her back when the 2 CNA's moved her too hard and fast. On 8/13/24 at 1:30 P.M., the facility investigation into the allegation of abuse by Resident N was reviewed. The investigation lacked information about staff who had cared for the resident, nor were these staff interviewed. There were no resident interviews completed regarding potential care concerns. On 8/14/24 at 1:13 P.M., the Administrator was interviewed and provided the current facility policy on Abuse Prohibition with steps to be taken if allegations made. The Administrator indicated she had been on an extended leave of absence and not present during the investigation of Resident N's allegation of abuse. Upon receiving an allegation of abuse, an immediate and thorough investigation should be completed. She indicated the investigation of Resident N's allegations had not been conducted thoroughly, according to facility policy, which indicated the following: .Upon the allegation of identification of abuse .it is the policy to assure safety of the resident involved during and after such allegation and to prevent further potential abuse . while the investigation is in progress .3. The Administrator and Director of Nursing will ensure investigation, including interviews, with all residents having the same potential to be affected by the accused person .All staff members on duty at the time of the alleged incident will also be interviewed regarding the witnessing of the alleged abuse. A list of such employees will be provided in the report so no one will be missed in the investigative process This citation relates to Complaint IN00439941, IN00440684, and IN00440721. 3.1-28(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37147 Based on interview and record review, the facility failed to develop and implement person-centered interventions to promote healing of pressure ulcers for 1 of 3 residents reviewed for pressure ulcers (Resident N). Findings include: On 8/16/24 at 1:28 P.M., Resident N's record was reviewed. Diagnoses included paraplegia (paralysis of legs and lower body) due to a progressive neurological disease, diabetes, and weakness. A significant change MDS (Minimum Data Set) assessment, dated 5/1/24, indicated the resident had no cognitive impairment, no moods, behaviors or rejection of care. She had impaired range of motion (ROM) to both her upper and lower extremities and was dependent on staff for toileting, bathing, bed mobility, transfers, and lower body dressing. She required maximal assistance with upper body dressing and personal hygiene. She had a new unstageable pressure ulcer (previous MDS assessment, dated 3/13/24, indicated the resident had no pressure ulcers). A Care Area Assessment (CAA), dated 5/14/24, indicated Resident N had an unstageable pressure ulcer to her right buttock which was being monitored and treated. She required assistance with activities of daily living, bed mobility, and care. She had a pressure relieving mattress in place on bed and preventative measures in place to help keep skin intact. Staff assisted her to change positions frequently, treatments done as ordered, and skin assessments completed as ordered. The CAA lacked indication the resident refused treatments or turning/repositioning recommendations. She had no specific written repositioning program. Current care plans were as follows: Dated 1/29/19: The resident preferred to sleep in her recliner and chose not to use the bed. Dated 4/10/24: The resident had developed a stage 4 (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer to her right buttock due to neurological disease, decreased mobility, weakness, and incontinence. The goal was for the pressure ulcer to heal without complications. Interventions included: administer treatment as ordered; nurse to measure and assess the wound weekly and notify MD as needed; pressure relieving mattress to bed and chair; turn and reposition a minimum of every 2 hours. Dated 5/4/18 and revised 5/14/24: The resident had behaviors which included; being resistant to care; refusing treatments, medication, and care; and making poor self care choices. The goal was to remain safe. Interventions were: care in pairs; document behaviors which were discussed in morning meetings; if more than 2 episodes/month, a behavior management note was to be written; and staff behavior interventions. The care plan lacked indication the resident refused wound treatments and turning/repositioning and lacked interventions to assess reasons for refusals such as pain or time preferences. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A health status note, dated 4/10/24 at 11:05 a.m., indicated the resident was observed with an area to her right buttock, which had changed in appearance. The facility wound nurse and NP (Nurse Practitioner) were notified and treatment orders obtained. A Wound Clinic progress note, dated 5/31/24 at 12:30 p.m., indicated the resident's right buttock wound was debrided (mechanically removed dead tissue) and classified as a stage 3 pressure ulcer (Full thickness tissue loss-Subcutaneous fat may be visible but bone, tendon or muscle is not exposed-Slough may be present but does not obscure the depth of tissue loss-May include undermining or tunneling). The facility was to obtain a wound vacuum to be applied to the wound and changed 3 times per week. The resident was to be encouraged to sleep in a bed with a specialty mattress and ROHO cushion obtained for her wheelchair and recliner chair. A Wound Clinic progress note, dated 6/10/24 at 12:45 p.m., indicated the resident had a new wound to her left buttock and continued with the wound vac to her right buttock wound. The resident indicated to the wound clinic facility staff were able to tip her side to side, but felt it could be done more often. Wound clinic recommendations and orders were to add a different adhesive to the base of the right buttock wound and continue with the wound vacuum. A dressing was ordered for a new left buttock wound. The resident was counseled to get her blood sugars below 200, at all times, increase the number of times her blood sugar was checked, continue with protein in her diet and protein shot supplement, and she must offload her ulcers and any other bony prominences every 2 hours. There were no changes made to Resident N's care plan for increased monitoring of blood sugars, turning/repositioning plan, or need for bed with a specialty mattress. A Wound Clinic progress note, dated 6/17/24 at 10:00 a.m., indicated the resident had a new pressure ulcer to her sacrum which measured 0.9 cm length x 0.5 cm width x 0.1 cm depth. Orders were to continue with the wound vacuum to the right buttock pressure ulcer, continue the same treatment to the left buttock wound, and cleanse the pressure ulcer to the sacrum with Kaltostat followed by dressing 3 times per week. She was to continue with eating high protein and her turning program. The TAR (Treatment Administration Record), dated April 2024, May 2024, June 2024, July 2024, and August 2024, indicated the resident refused wound treatments on 5/19/24 and 6/19/24. The TAR, dated June 2024, lacked an order to cleanse the pressure ulcer to the sacrum with Kaltostat followed by a dressing 3 times per week and there was no treatment completed to the sacral wound. A Wound Clinic progress note, dated 6/24/24 at 1:45 p.m., indicated the residents right buttock pressure ulcer measured larger/deeper and was tender to touch. Her left buttock pressure ulcer was unchanged and the sacral pressure ulcer was healed. The wound vacuum was to continue to the right buttock wound and current treatment continued for the left buttock wound. A Wound Clinic progress note, dated 7/19/24 at 1:45 p.m., indicated the resident was seen for continued treatment to her right and left buttock wounds. The wound vac was to continue to the right buttock wound and mepilex dressing applied to the left buttock. Progress notes indicated Resident N refused care/turning/repositioning on the following days: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/3/24; resident indicated she hadn't needed any care at the time. Staff were to reapproach at a later time. There was no follow up note. 5/9/24; the resident hadn't wanted her wounds measured and dressing changed until after her shower. The wounds were not assessed or dressing changed. 6/19/24; resident refused wound vac treatment because she hadn't wanted to be in pain all night. 6/26/24; the resident refused to get up and go to lunch in activity room because the battery in my wound vac is low and I can't leave my chair. 6/28/24; resident refused left buttock wound change because she hadn't wanted to roll so many times due to the pain. 7/9/24; refused attempts to assist with repositioning and indicated she was ok. 7/10/24; refused to be turned at 8:30 a.m. because she was comfortable in the current position; refused wound care to left buttock due to not wanting to roll so many times. 7/15/24; resident refused to be repositioned at a time staff were wanting her to reposition. 7/22/24; resident refused wound care due to her pain medication worn off and having had a procedure done during the day. On 8/13/24 at 10:55 A.M., Resident N was interviewed. She was observed seated in her oversized recliner chair in her room. A bed with a pressure reducing mattress sat on the other side of the room without linens and personal items strewn across. The resident indicated she slept in her reclining chair which could be sat straight up or laid down completely. She was observed with her right buttock elevated and she indicated there was a pillow below it. She indicated she had a sore on her bottom present since October 2023. She'd had a wound vacuum on it but it had been taken off until her next appointment with the wound clinic on 8/15/24. On 8/14/24 at 1:15 P.M., the Administrator, Director of Nursing (DON) and facility wound nurse were interviewed. All present indicated weekly wound assessments had not been completed per the facility policy. The care plan had not been updated with interventions regarding refusals of wound care and education on consequences of refusals. There had been no specific turning/repositioning program put in place nor further assessments completed when the resident refused to turn/reposition. The resident's new sacral wound identified by the wound clinic and orders given to treat on 6/17/24, should have been implemented, but had been missed. The wound had healed without treatment on 6/24/24. A policy titled Wound Care Guidelines, amended 8/14/24 and provided at 1:13 P.M. by the DON indicated wounds were to be assessed and documented on weekly including measurements and treatments. This Citation relates to Complaints IN00439941, IN00440684, and IN00440721. 3.1-40(a)(1) 3.1-40(a)(2)