

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/03/2024
NAME OF PROVIDER OR SUPPLIER  Cedar Creek Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE  18275 Burr Street Lowell, IN 46356	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>32664</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents received the necessary care for activities of daily living care (ADL) related to long unkempt fingernails and the lack of offering residents shaving per the plan of care for 2 of 3 residents reviewed for ADL care. (Residents 21 and 26)</p> <p>Findings include:</p> <p>1. On 4/29/24 at 11:19 a.m., Resident 21 was observed lying in bed in her room. Her fingernails were long, thickened and discolored. The resident indicated she would like them trimmed and no one had offered to trim them.</p> <p>On 5/1/24 at 11:07 a.m., and again on 5/2/24 at 9:07 a.m., Resident 21 was observed in her room. Her fingernails were still long, thickened and discolored.</p> <p>Record review for Resident 21 was completed on 5/1/24 at 2:33 p.m. Diagnoses included, but were not limited to diabetes mellitus, dementia, stroke, and Parkinson's disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 2/21/24, indicated the resident was moderately cognitively impaired. The resident had an impairment on one side of the upper and lower extremities for a functional limitation in range of motion. The resident required a substantial assistance with personal hygiene.</p> <p>A Care Plan, dated 1/5/21 and revised 2/22/24, indicated the resident had a diagnosis of cerebrovascular accident (stroke) with right hemiparesis/hemiplegia (weakness, paralysis) requiring assistance with ADL care.</p> <p>During an interview on 5/2/24 at 9:42 a.m., CNA 1 indicated residents' nails were offered to be cut when they receive bathing. This was her first shift back from being off for 5 days and she had noticed Resident 21's fingernails needed to be cut.</p> <p>During an interview on 5/2/24 at 11:45 a.m., the Director of Nursing (DON) indicated the nurse was able to soak the resident's fingernails, cut them a little and then clean underneath of them. The resident had a fungus on her nails and had an antifungal ointment applied to them daily. She acknowledged the staff should have attempted to soak and cut her fingernails before today.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45666</p> <p>2. On 4/29/24 at 10:00 a.m., Resident 26 was noted in bed. He had grown out facial hair and his hair was disheveled.</p> <p>On 4/30/24 at 2:43 p.m., Resident 26 was noted in his room in bed. He had facial hair and his hair was disheveled.</p> <p>Resident 26's record was reviewed on 4/30/24 at 2:58 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, cognitive communication deficit, and Parkinson's disease.</p> <p>A Care Plan, dated 4/5/23, indicated the resident required staff assistance to complete ADL tasks completely and safely. Interventions included, but were not limited to, offer facial shaving on shower days, as needed, or as requested. Notify nursing of refusals.</p> <p>There was no documentation available in the record related to the resident receiving assistance with shaving.</p> <p>During an interview on 5/1/24 at 10:55 a.m., the DON indicated the resident had an electric razor that had broken. They were trying to get it replaced, but the staff were unable to get in touch with the resident's son. The DON was unable to provide any further documentation.</p> <p>During a follow-up interview on 5/1/24 at 1:45 p.m., the DON indicated shaving was considered basic care and they do not have to document it in the record.</p> <p>3.1-38(a)(3)(D)</p> <p>3.1-38(a)(3)(E)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>32788</p> <p>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 3 of 3 residents reviewed for non-pressure related skin conditions. (Residents 38, 4, and 26)</p> <p>Findings include:</p> <p>1. On 4/29/24 at 2:12 p.m., Resident 38 was observed sitting in her wheelchair in her room. Dark purple discolorations were noted to the tops of both hands and she had a bandaid on her right wrist.</p> <p>On 4/30/24 at 2:29 p.m., Resident 38 was observed sitting in her wheelchair in her room. The dark purple discolorations remained to the tops of both hands. She had bandaids on her left hand and right wrist.</p> <p>On 5/1/24 at 8:52 a.m., Resident 38 was observed sitting in her wheelchair in her room. The dark purple discolorations remained to the tops of both hands, and she had a bandaid on her right hand.</p> <p>Record review for Resident 38 was completed on 4/30/24 at 2:14 p.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, congestive heart failure.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 3/29/24, indicated the resident was cognitively impaired. She required substantial assistance with lower body dressing and partial assistance with upper body dressing. She had received antiplatelet medications.</p> <p>A current care plan, updated 4/29/24, indicated the resident was at risk for excessive bleeding and bruising due to her medications.</p> <p>The Medication Administration Record (MAR), dated 4/2024, indicated the resident was receiving clopidogrel (an antiplatelet medication) 75 mg (milligrams) daily.</p> <p>An Event, dated 3/22/24, indicated the resident was admitted with skin discolorations to the left elbow, left forearm, right elbow, right and left arms and hands. The event was closed on 3/27/24 and the evaluation note indicated the discolorations were in various stages of healing. There was a lack of any further follow up with the skin discolorations.</p> <p>A Progress Note, dated 4/30/24, indicated the resident had a blood draw to the right hand and a bandage was applied.</p> <p>A Progress Note, dated 4/28/24, indicated the resident had a blood draw to the right hand and a bandage was applied.</p> <p>A Progress Note, dated 4/24/24, indicated the resident had a blood draw to the left hand and a bandage was applied.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Weekly Skin Assessments, dated 4/12/24, 4/19/24, and 4/26/24, indicated there were old skin impairments but no new skin issues.</p> <p>During an interview with the Director of Nursing (DON) on 5/1/24 at 10:54 a.m., she indicated the resident had recent blood draws and was a hard stick, which is probably what caused the skin discolorations and was why she had the bandaids on. She would start a skin event.</p> <p>2. On 4/29/24 at 2:05 p.m., Resident 4 was observed sitting in his wheelchair in his room. He had his right pant leg pulled up and was pointing at his right knee. The was a large scabbed area to his right knee.</p> <p>On 4/30/24 at 2:31 p.m., Resident 4 was observed sitting in his wheelchair in his room. He had both pant legs pulled up and the large scabbed area remained to his right knee.</p> <p>Record review for Resident 4 was completed on 4/30/24 at 11:37 a.m. Diagnoses included, but were not limited to, dementia, pulmonary fibrosis, and hyperlipidemia.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 3/16/24, indicated the resident was cognitively impaired. He was dependent on staff for lower body dressing and substantial assist with upper body dressing.</p> <p>A current care plan, updated 3/14/24, indicated the resident was at risk for alterations in skin integrity. The interventions included, .observe my skin during routine caregiving for acute changes</p> <p>A Progress Note late entry, dated 4/18/24 at 12:43 a.m., indicated the resident had a fall on 4/17/24 and was observed sitting at the foot of his bed. The note indicated, . Resident skin has no injuries. Right knee was red from kneeling on the floor. Is blanchable There was lack of any further documentation to indicate the resident had a scabbed area to the right knee.</p> <p>The Weekly Skin Assessments, dated 4/15/24, 4/22/24, and 4/29/24, indicated there were old skin impairments but no new skin issues.</p> <p>During an interview with the Director of Nursing (DON) on 5/1/24 at 10:54 a.m., she indicated the resident had a fall on 4/17/24 and the nurse had documented the right knee was red. The area had probably scabbed over after that. There was no further monitoring of the right knee and the weekly skin assessments had not indicated any new areas of skin impairment.</p> <p>45666</p> <p>3. On 4/29/24 at 10:00 a.m., Resident 26 was observed in his room. He had discolorations to his left forearm with a small abrasion.</p> <p>On 4/30/24 at 2:42 p.m., Resident 26 was observed in his room. He had discolorations to his left forearm with a small abrasion.</p> <p>Resident 26's record was reviewed on 4/30/24 at 2:58 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance and Parkinson's disease.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Annual Minimum Data Set (MDS) assessment, dated 3/5/24, indicated the resident was severely cognitively impaired for daily decision making. He required assistance from staff for activities of daily living (ADLs) including bathing and personal hygiene.</p> <p>A Care Plan, dated 5/17/23, indicated the resident had a potential for alterations in skin integrity. Interventions included, but were not limited to, complete a weekly skin assessment via a licensed nurse and observe the skin during routine caregiving for acute changes.</p> <p>There was no documentation available in the resident's record related to the abrasion and discoloration on the left forearm.</p> <p>During an interview on 5/1/24 10:55 a.m., the Director of Nursing indicated Resident 26 had self-propelled throughout the facility a lot. The staff had assessed the area and said it was an old abrasion from self-propelling. She was unable to provide any additional information.</p> <p>3.1-37(a)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32664</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary treatment to prevent a decrease in range of motion related to leg rests and a foot board improperly positioned on a wheelchair for 1 of 1 residents reviewed for positioning and mobility. (Resident 154)</p> <p>Finding includes:</p> <p>On 4/30/24 at 2:41 p.m., Resident 154 was sitting in a wheelchair in the dining area of the memory care unit on the Assisted Living side of the facility. The resident was sitting with other residents who were participating in an activity. The resident was observed to have leg rests and a foot board attached to the end of her wheelchair. The leg rests and footboard were extended horizontally out aligned with the wheelchair. Underneath the resident's legs and feet was a pillow on top of the leg rests. When the resident extended her feet they would extend over the foot board so she would then pull her legs back into a bent position. The resident had attempted multiple times to move her feet off of the leg rests and place them onto the floor. An Activity Aide was sitting next to the resident, and each time the resident attempted to put her feet onto the floor, the Activity Aide would place her feet back onto the leg rests and ask the resident to keep her feet in the wheelchair. During an interview at the time of this observation, Activity Aide 1 indicated the resident's feet were always up on the leg rests because she would try and stand and then would fall down.</p> <p>Record review for Resident 154 was completed on 4/30/24 at 11:55 a.m. Diagnoses included, but were not limited to, dementia, anxiety, right radius (forearm bone) fracture, and repeated falls.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 4/11/24, indicated the resident was severely cognitively impaired. The resident was dependent with transfers and used a wheelchair.</p> <p>A Care Plan, dated 4/4/24 and revised 4/29/24, indicated the resident was at risk for falling related to a history of falls, impulsiveness, and unsteady gait. Interventions included, fix left wheelchair brake, apply a wedge cushion to wheelchair seat, and staff to assist resident with transfers as needed.</p> <p>A Care Plan, dated 4/4/24, indicated the resident had a potential for decline in functional status related to dementia with a history of falls due to unsteady gait, being impulsive, arthritis and scoliosis. Interventions included for adaptive equipment as ordered, and to encourage the resident to do as much for self as safely possible.</p> <p>A Progress Note, dated 4/6/24 at 11:14 a.m., indicated the resident was on the floor on her knees in the activity room.</p> <p>An IDT Progress Note, dated 4/6/24 at 1:43 p.m., indicated the resident a fall without injury on 4/6/24. The cause of the fall was moving her legs to the side of her chair, then attempting to stand. An intervention included to apply a wedge cushion to the wheelchair seat. Therapy services were aware.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Progress Note, dated 4/22/24 at 6:39 p.m., indicated staff were observed lowering the resident from her wheelchair foot pedals/board to the floor alongside dining table. The resident had exhibited baseline restlessness and mental status while shimmying from the seat of the wheelchair quickly to the foot pedals. The staff observed the wheelchair take a [NAME]-totteraction when the resident's weight rested on the foot pedals. Three staff members intervened to lower the resident to the dining area floor.</p> <p>A Progress Note, dated 4/27/24 at 6:31 p.m., indicated the resident was in the dining room. The resident was placed at the table and the brakes were locked on the wheelchair. The resident was then observed pushing her chair back with her legs and feet over the side of the foot rest. The resident turned her wheelchair on its side. The resident's leg was still on the footrest. Staff assisted the resident up and back into her wheelchair. No injuries were noted at the time. The resident's daughter was informed of the incident and indicated that her mother was attempting to get up and putting her feet and legs over the foot rest earlier when she had visited.</p> <p>An Occupational Therapy Evaluation and Plan of Treatment with Certification Period: 4/4/24-5/3/24, indicated the resident's current seating was a standard wheelchair with adaptive equipment/devices including leg rests.</p> <p>The Occupational Therapy Evaluation did not include how high the leg rests should be attached to the wheelchair.</p> <p>During an interview on 4/30/24 at 2:57 p.m., the Director of Nursing (DON) indicated the resident had her feet and legs up on legs rests at all times and was unaware why. She would look into it.</p> <p>During an interview on 5/1/24 at 8:28 a.m., the DON indicated she had removed the resident's leg rests yesterday evening and observed the resident for a little while. The resident did try to move her feet around and use her hands to turn the wheelchair wheels. She also tried to stand so they had to assist her so she would not fall. She indicated the leg rests should not have been up that high since the resident was able to propel herself. She would speak to therapy to see if they recommended the leg rests and foot board.</p> <p>During a follow up interview on 5/1/24 at 8:48 a.m., the DON indicated therapy had recommended the leg rests and foot board for positioning.</p> <p>During an interview on 5/1/24 at 9:38 a.m., the Therapy Director (TD) indicated they did recommend the leg rests and foot board for positioning and for safety when staff propelled the resident in the wheelchair. The leg rests and foot board were intended for the resident to sit up straight. The positioning of the leg rests and footboard should be just off of the ground and not straight out horizontally from the wheelchair. The TD was unaware of the recent incidents in which the resident was involved with her almost tipping her chair when she sat on her leg rests, and then when she turned her wheelchair over in the dining room. She would in-service her staff to do better documentation on the assistive devices they recommend. The documentation should have included how high the resident's feet and legs should have been lifted off of the ground so the nursing staff would know.</p> <p>3.1-42(a)(2)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>45666</p> <p>Based on observation, record review, and interview, the facility failed to ensure a gastrostomy tube (g-tube) was properly checked for placement prior to medication administration for 1 of 16 residents observed during medication pass. (Resident 21)</p> <p>Finding includes:</p> <p>During a medication pass observation on 5/2/24 at 12:03 p.m., LPN 1 was observed preparing medications for Resident 21. She performed hand hygiene, popped two carbidopa 25 milligram (mg) tablets into a medication cup, poured the tablets into a crush bag, crushed the medication, and then put them back into the medication cup. She prepared two carbidopa-levodopa 25-100 mg tablets into a separate cup, crushed them in a bag, and then placed them back into the medication cup. She then mixed 15 milliliters (ml) of water with each medication and prepared two 30 ml and one 15 ml cup of water for flushes.</p> <p>Upon entrance to the resident's room, LPN 1 performed hand hygiene and donned a gown and gloves. She paused the g-tube feeding and then proceeded to check the resident's g-tube for placement with an air bolus by plunging air with a syringe into the tube. She poured a 30 ml flush into the tube, then the carbidopa medication, the 15 ml water flush, carbidopa-levodopa medication, then the 30 ml water flush. She reattached and resumed the g-tube feeding.</p> <p>During an interview on 5/2/24 at 12:21 p.m., LPN 1 indicated she was supposed to check for placement by removing residual from the g-tube per the facility policy, not with an air bolus.</p> <p>During an interview on 5/2/24 at 3:48 p.m., the Director of Nursing indicated she had no further information to provide.</p> <p>A Policy titled, Specific Medication Administration Procedures, indicated .L. With gloves on, check for proper tube placement using air and auscultation only. Never check placement with water. M. Check gastric content for residual feeding. Return residual volumes to the stomach. Report any residual about 100 ml.</p> <p>3.1-44(a)(2)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45666</p> <p>Based on observation and interview, the facility failed to ensure medications were stored appropriately related to unidentified and crushed pills found in medication cart drawers for 2 of 2 medication carts reviewed. (100 and 300 Hall carts)</p> <p>Findings include:</p> <p>1. The 100 Hall Medication Cart was observed on 5/2/24 at 9:06 a.m. with RN 1. Upon review, there were multiple unidentified whole pills on the bottom of the drawer. The corner of the third drawer was covered with crushed up medications.</p> <p>During an interview at the time, RN 1 indicated the night shift staff was supposed to clean out the medication carts during their shift.</p> <p>During an interview on 5/2/24 at 8:58 a.m., the Director of Nursing was notified of the medications found in the medication cart and she had no further information to provide.</p> <p>2. The 300 Hall Medication Cart was observed on 5/2/24 at 1:51 p.m. with RN 2. Upon review, there were two unknown whole pills on the bottom of the drawer.</p> <p>During an interview at the time, RN 2 indicated the night shift staff was supposed to clean out the medication carts during their shift.</p> <p>During an interview on 5/2/24 at 8:58 a.m., the Director of Nursing was notified of the medications found in the medication cart and she had no further information to provide.</p> <p>A Policy titled, Medication Storage in the Facility, indicated, .C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label . H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal .</p> <p>3.1-25(o)</p>