STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155822	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Creek Health Campus	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 32582 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 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) (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155822	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Creek Health Campus	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-7(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155822	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Creek Health Campus	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 45666 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, 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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155822	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Creek Health Campus	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32582 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 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. 45666 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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155822	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Creek Health Campus	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155822	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Creek Health Campus	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45666 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 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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155822	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Creek Health Campus	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-41(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155822	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Creek Health Campus	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 32582 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 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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155822	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Creek Health Campus	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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 32582 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 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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155822	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Creek Health Campus	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45666 Based on observation, record review and interview, the facility failed to ensure infection control guidelines were in place and implemented 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)