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	05/18/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to insulin for 1 of 16 MDS assessments reviewed. (Resident 15)Finding includes:Record review for Resident 15 was completed on 5/12/26 at 3:16 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus.The admission MDS assessment, dated 3/17/26, indicated the resident had received an insulin injection in the past seven days.The Medication Administration Record, dated 3/2026, lacked documentation of any insulin administration.The Physician's Order Summary, dated 5/2026, lacked any orders for insulin.During an interview on 5/13/26 at 3:05 p.m., the MDS Coordinator indicated the resident had not received any insulin and it had been marked by accident.410 IAC (Indiana Administrative Code) 16.2-3.1-31(i)

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure care plans were implemented and in place for antibiotic medication use for 1 of 16 resident care plans reviewed. (Resident 3)Finding includes:During an interview on 5/12/26 at 11:00 a.m., Resident 3's family member indicated the resident was taking antibiotics routinely due to a history of urinary tract infections in the past.Resident 3's record was reviewed on 5/12/26 at 1:26 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance and urinary tract infection.The Quarterly Minimum Data Set (MDS) assessment, dated 3/4/26, indicated the resident was severely cognitively impaired, she was frequently incontinent of bowel and bladder, and received antibiotic medications.A Physician's Order, dated 1/22/26, indicated Macrobid (antibiotic medication) 100 milligrams, 1 capsule daily.A Physician's Progress Note, dated 1/22/26 at 12:02 p.m., indicated the resident was seen for a follow-up per the family's request for a lump on the resident's right knee with pain and for concerns of a urinary tract infection (UTI). The resident was a candidate for prophylactic antibiotics (medication used for prevention of bacterial infection) given the history of recurrent UTIs. Macrobid 100 milligrams daily was ordered for UTI prevention.There was no care plan implemented related to the prophylactic use of antibiotic medications.During an interview on 5/18/26 at 3:15 p.m., the Director of Nursing indicated the MDS Coordinator had overlooked the antibiotic, and a care plan had not been initiated.410 IAC (Indiana Administrative Code) 16.2-3.1-35(a)

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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. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to skin discolorations not assessed and or monitored for 2 of 3 residents reviewed for non-pressure related skin conditions. (Residents 4 and 35)Findings include:1. On 5/11/26 at 10:19 a.m., Resident 4 was observed sitting in a wheelchair in her room. The resident had a raised blue discoloration on her right forearm and a purple discoloration on her left shin. The resident indicated she was unsure how she received the discolorations. Record review for Resident 4 was completed on 5/12/26 at 1:29 p.m. Diagnoses included, but were not limited to, atrial fibrillation, stroke, and heart failure. A Care Plan, dated 4/30/26, indicated the resident was at risk for excessive bleeding and bruising related to medications. An intervention included to notify the physician of abnormal bruising.The admission Minimum Data Set (MDS) assessment, dated 5/4/26, indicated the resident was moderately cognitively impaired. The resident had a functional limitation in range of motion to one side of her upper and lower extremities. The resident required substantial maximal assistance with dressing and was dependent on staff for transfers. The resident received an anticoagulant (blood thinning) medication. The May 2026 Physician's Order Summary indicated the resident had received Eliquis (anticoagulant medication) 2.5 milligrams twice a day for atrial fibrillation. On 5/12/26 at 2:42 p.m., Resident 4 was observed lying in bed with a blanket over her legs. The resident had a raised blue discoloration on her right forearm.There was a lack of documentation to indicate the skin discolorations had been assessed and or monitored.During an interview on 5/12/26 at 2:44 p.m., RN 1 indicated she was unaware of the resident's discolorations. Staff should have identified the discolorations during routine care. 2. On 5/11/26 at 10:15 a.m., Resident 35 was observed sitting in a wheelchair in her room. The resident had a large dark purple discoloration on her right hand.On 5/12/26 at 9:13 a.m., Resident 35 was observed sitting in a wheelchair in the dining area. The resident had a large dark purple discoloration on her right hand.Record review for Resident 35 was completed on 5/12/26 at 3:00 p.m. Diagnoses included, but were not limited to, dementia, peripheral vascular disease, and stroke.A Care Plan, dated 10/7/20, indicated the resident was at risk for excessive bleeding and bruising. An intervention included to notify the physician of abnormal bruising and or bleeding. A Weekly Skin Assessment, dated 5/5/26, indicated the resident had no impairment.There was a lack of documentation to indicate the skin discoloration had been assessed and or monitored.During an interview on 5/12/26 at 3:05 p.m., RN 1 indicated she was unaware of the resident's discoloration. Staff should have identified the discoloration during routine care. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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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. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary care and treatment related to a lack of a Physician's Order for oxygen use for 1 of 2 residents reviewed for respiratory care. (Resident 4)Finding includes:On 5/11/26 at 10:19 a.m., Resident 4 was observed sitting in a wheelchair in her room. The resident had a portable oxygen concentrator hooked to the back of her wheelchair. The oxygen was on the resident via a nasal canula at 2 liters. The resident indicated she had been on oxygen for a while. Record review for Resident 4 was completed on 5/12/26 at 1:29 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and respiratory failure. A Care Plan, dated 4/30/26, indicated the resident had potential for shortness of breath while lying flat related to COPD. An intervention included to administer oxygen per the Physician's Order.The admission Minimum Data Set (MDS) assessment, dated 5/4/26, indicated the resident was moderately cognitively impaired. The resident had a functional limitation in range of motion to one side of her upper and lower extremities. The resident required substantial maximal assistance with dressing and was dependent on staff for transfers. The resident received oxygen therapy.A Physician's Order, dated 5/12/26, indicated to administer oxygen at 2 liters per nasal canula continuously.There was no documentation indicating a Physician's Order for oxygen administration was in place prior to 5/12/26. During an interview on 5/12/26 at 2:44 p.m., RN 1 indicated the resident had been on oxygen for a while. She was unsure why there was not a Physician's Order for oxygen prior to 5/12/26. 410 IAC (Indiana Administrative Code)16.2-3.1-47(a)(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to Enhanced Barrier Precautions (EBP) and staff not wearing a gown during a peripherally inserted central catheter (PICC) medication administration observation. (Resident 22) Finding includes:During a medication administration observation on 5/14/26 at 12:54 p.m., LPN 1 was observed preparing Resident 22's medications, which included antibiotic medication to be administered intravenously through the resident's PICC line. The resident's doorway had a sign that indicated EBP was to be used. LPN 1 entered the resident's room, used hand sanitizer, and donned gloves. He had not donned a gown. He then proceeded to administer the intravenous medication through the PICC line. During an interview on 5/14/26 at 1:07 p.m., LPN 1 indicated he had not been instructed to wear a gown when administering intravenous medication through a PICC line. He was unsure if the resident had an EBP sign posted outside his door.During an interview on 5/15/26 at 8:52 a.m., the Infection Preventionist indicated a gown and gloves should be worn when administering intravenous medication through a PICC line.A facility policy, titled, Enhanced Barrier Precautions Standard Operating Procedure, received as current, indicated .1. Enhanced barrier precautions will be in place during high contact care activities for residents with the following conditions: .ii. All residents with indwelling medical devices. 1. Includes but not limited to: catheters, central lines, feeding tubes, tracheostomy tubes .2. Personal protective equipment should be used even if blood and body fluid exposure is not anticipated. a. At minimum, staff shall wear gloves and gowns during high contact care activities .410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure a call light was working for a dependent resident for 1 of 24 resident's call lights tested. (Resident 4)Finding includes:On 5/11/26 at 10:19 a.m., Resident 4 was observed sitting in a wheelchair in her room. The resident indicated she wanted to lie down. She had pushed the button on her call light, but no one had responded. The resident pushed the button again; there was no light that illuminated from the call system in the hallway. On 5/11/26 at 10:21 a.m., LPN 1 was notified the resident's call light was not working. She then proceeded into the resident's room and pushed the button on the call light. There was no light that illuminated from the call system in the hallway. She indicated she would inform maintenance to fix the call light and would get another staff member to help her lie down.Record review for Resident 4 was completed on 5/12/26 at 1:29 p.m. Diagnoses included, but were not limited to, stroke and hemiplegia (paralysis on one side of the body).The admission Minimum Data Set (MDS) assessment, dated 5/4/26, indicated the resident was moderately cognitively impaired. The resident had a functional limitation in range of motion to one side of her upper and lower extremities. The resident was dependent on staff for transfers. 410 IAC (Indiana Administrative Code) 16.2-3.1-19(u)