PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-039

CE.TEROTOR	THE CONTENTS	ALL SELL LOUIS				0.11.	21.0.0,000
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUC		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING			05/09/2024	
				_	<u> </u>		= .
NAME OF F	PROVIDER OR SUPPLIE	 R			ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	NO VIDER OR SOLVEID			297 SC	OUTH 100 EAST		
CEDAR (CREEK OF WASHI	NGTON		WASHI	INGTON, IN 47501		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S DLAN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		\IE	DATE
R 0000							
Bldg. 00							
g. 00	This visit was for the	he Investigation of Complaints	R 0	000	Submission of this response a	and	
	IN00430562 and IN	-	I K U	000	Plan of Correction is NOT a le		
	11100430302 and 11	100727773.			admission that a deficiency ex	-	
	Complaint IN0043	0562 - No deficiencies related to			1	(ISIS	
	the allegations are				or, that this Statement of	l	
	the anegations are	cited.			Deficiencies was correctly cite		
	C 1 . (IN10042)	0445 54 1 6			and is also NOT to be constru		
	_	9445 - State deficiencies related			as an admission against inter	est	
	to the allegations as	re cited at R2/3.			by the residence, or any		
	G 1. 36	0 10 2024			employees, agents, or other		
	Survey dates: May 8 and 9, 2024				individuals who drafted or ma	-	
					discussed in the response or	Plan	
	Facility number: 00	04904			of Correction. In addition,		
	Residential Census: 20 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.				preparation and submission of		
					Plan of Correction does NOT		
					constitute an admission or		
					agreement of any kind by the		
					facility of the truth of any facts	3	
					alleged or the correctness of	any	
	Quality review completed May 15, 2024.				conclusions set forth in this		
					allegation by the survey agen	cy.	
R 0273	410 IAC 16.2-5-5	* *					
	Food and Nutritio	nal Services - Deficiency					
Bldg. 00							
		on and interview, the facility	R 0	273	Submission of this response a	and	05/09/2024
	failed to ensure the	dishwasher was monitored for			Plan of Correction is NOT a le	∍gal	
	1 of 2 observations. Chemical test strips to test the chlorine level for effective sanitation in a low				admission that a deficiency ex	xists	
					or, that this Statement of		
	temperature dishwa	asher was not completed.			Deficiencies was correctly cite	∍d,	
					and is also NOT to be constru	ıed	
	Findings include:				as an admission against interest		
					by the residence, or any		
	On 5/9/24 at 9:30 A.M., during observation of the kitchen the facility was observed to be recording temperatures in the morning and evening on the low temperature dishwasher. The facility was not				employees, agents, or other		
					individuals who drafted or ma	y be	
					discussed in the response or	-	
					of Correction. In addition,	-	
	using chemical test strips to test the chlorine. The				preparation and submission of	of this	
	asing chemical test surps to test the emornic. The				1	1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED	
			B. WING			05/09/2024	
	l .		DEET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	₹			UTH 100 EAST			
CEDAR (NCTON			NGTON, IN 47501			
CEDAR	CREEK OF WASHI	NG TON	V	MOUII	NG FOIN, IIN 4750 F		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRE	FIX	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TA	AG	DEFICIENCY)	DATE	
	temperature of the	dishwasher was observed to be			Plan of Correction does NOT		
	104 degrees Fahren	heit during the rinse cycle. At			constitute an admission or		
	that time, the Dietar	ry Manager indicated when she			agreement of any kind by the		
	started in February,	the chemical test strips were			facility of the truth of any facts		
	expired. The Dietar	y Manager asked the dietician		alleged or the correctness of any			
	about utilizing cher	nical strips to make sure the			conclusions set forth in this		
	chemicals were cor	rect for sanitizing the dishes.			allegation by the survey agend	cy.	
	The Dietary Manag	er indicated the dietician told			- -		
	her to ask maintena	nce personnel. The Corporate					
	Maintenance indica	ited to use the watch			R 273 410 IAC 16.2-5-5.1(f) Fo	pod	
	temperatures for the	eir dishwasher. The Dietary			and Nutritional Services -		
	Manager indicated	she would call the			Deficiency		
	manufacturer of the	e dishwasher to get a definitive					
	answer.				What corrective action(s) wil	ı	
					be accomplished for those		
	During an interview	v on 5/9/24 at 10:42 A.M., the			residents found to have been	n	
	Regional Director indicated the company had not				affected by the deficient		
	called back, but the corporate office indicated				practice:		
	chemical strips should be used.						
					No residents were found to ha	ive	
	On 5/9/24 at 10:49	A.M., the Dietary Manager			been affected by this deficient		
	indicated she found chemical test strips and the				practice.		
	dishwasher tested at 100 ppm (parts per million)			2. How the facility will identify			
	for chlorine. The Dietary Manager indicated this			other residents having the			
	was an acceptable result for the chemical concentration.				potential to be affected by th	е	
					same deficient practice and		
					what corrective action will be	e	
	During an interview on 5/9/24 at 10:57 A.M., the				taken:		
	Regional Director indicated there had not been				The Executive Director and		
	any digestive illnesses in the residents.			Director of Nursing observed			
					residents that had the potentia	al to	
		A.M., the Regional Director			be affected by this practice. N	0	
	indicated they did not have a policy for the			other residents were found to have			
	dishwasher but follow the instructions on			been affected by this deficient			
	chemical testing the dishwasher twice a day per			practice.			
	corporate's recomm	endations.			3. What measure will be put		
					into place or what systemic		
	This citation relates	s to Complaint IN00429445.			changes the facility will make	e	
	·				to ensure that the deficient		
					practice does not reoccur:		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
			B. WING			05/09/2024		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIE	R			OUTH 100 EAST			
CEDAR CREEK OF WASHINGTON					NGTON, IN 47501			
					1		1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF COM			(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
					Chemical test strips will be us	ea		
					to test the chlorine level for			
					effective sanitation with the lo			
					temperature dishwasher after			
					every meal service (3 times every day)			
					The Dining Comitee Director of			
					The Dining Service Director of designee will train all Dining	I		
					Services staff on how to use			
					chemical test strips to test the			
					chlorine level for effective			
					sanitation in a low temperature	_		
				dishwasher		C		
					dionwachor			
					4. How the corrective action((s)		
					will be monitored to ensure t	the		
					deficient practice will not			
					recur, i.e., what quality			
					assurance program will be p	ut		
					into place:			
					The Executive Director is			
					responsible for sustained			
					compliance. The ED/designee	will		
					complete audits by checking t	he		
					documentation of the use of			
					chemical strips weekly for 4			
					weeks, biweekly for 4 weeks,			
					monthly for 1 month to ensure	;		
					compliance. The audit willbe			
					discussed in weekly 1:1 meeti	•		
					with the Dining Service Direct	or.		
					Monitoring will be on-going.			
					5. By what date will the			
					systemic changes be			
					completed?			
					Systemic changes were			
			1		implemented by the Dining Se	ervice		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
			B. WING			05/09/2024		
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF WASHINGTON				STREET ADDRESS, CITY, STATE, ZIP COD 297 SOUTH 100 EAST WASHINGTON, IN 47501				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					Director on May 9, 2024, and be ongoing.	will		

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