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

FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 03/19/2024 |

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| CEDAR CREEK OF WARSAW | 425 CHINWORTH CT<br>WARSAW, IN 46580 |

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey.<br><br>Survey dates: March 18 & 19, 2024<br><br>Facility number: 011389<br><br>Residential Census: 26<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on 3/27/24. | R 0000 | | |
| R 0116<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(a)<br>Personnel - Noncompliance<br>(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.<br>Based on record review and interview, the facility failed to obtain references for prospective employees before hiring, for 1 of 5 new employee files reviewed. (Cook 5)<br><br>Finding includes:<br><br>Employee Records were reviewed on 3/18/2024 at 1:10 P.M. No pre-employment reference check had been completed for Cook 5 with a hire date of 2/20/24.<br><br>During an interview, on 3/19/2024 at 9:02 A.M., | R 0116 | **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>An audit took place on 4/4/2024 of staff charts to identify all staff members who did not have references obtained during the new hire process. Those staff members who were identified as not having references obtained upon hire will have references | 04/14/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Marcie Fisher | Executive Director | 06/05/2024 |

Any defiencystatement 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 disclo 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.

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| | the Executive Director indicated she had not obtained references for Cook 5. She indicated that she did not obtain a reference during the hiring process, but after an offer letter was extended, she would then complete the reference checks. She indicated reference checks should have been completed.<br><br>A policy was requested, on 3/19/2024 at 8:07 A.M. The Executive Director indicated that a policy was not available for employee references. At 10:18 A.M., she provided a document titled, "New Employee Hiring Checklist". The checklist indicated, "Documents for Employee's Confidential Red Personnel File ...Required-Past Employment Phone and/or Written Reference Checks Forms ...." | | obtained and added to file upon completion.<br>**2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**<br>All residents had the potential to be affected by this deficient practice. The ED will review all staff files to ensure that references have been completed for all staff. Any staff members that do not have completed reference checks on file will be rectified.<br>**3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:**<br>The Executive Director (ED) was re-educated on 3/18/2024 on the Indiana State rule requiring references be obtained for all new hires upon hire. Current staff who are identified as not having completed references, the ED will work to obtain those references retroactively. The Executive Director will ensure that references are obtained for new hires during the hiring process.<br>**4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.., what quality assurance program will be put into place:**<br>The Executive Director is | |

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| | | | responsible for sustained compliance. The ED/designee will complete audits for all new hires 3 days prior to their start date for 2 months. The audit willbe discussed at monthly IDT meetings. The ED will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.<br>**5 By what date will the systemic changes be completed?**<br>4/14/2024 | |
| R 0246<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(6)<br>Health Services - Deficiency<br>(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.<br>Based on record review and interview, the facility failed to have a Qualified Medication Aide (QMA) receive prior authorization to administer an as needed (prn) medication from a qualified licensed professional for 1 of 7 records reviewed for medication administration. (Resident 3)<br><br>Finding includes:<br><br>A record review for Resident 3 was completed on 3/18/2024 at 10:37 A.M. Diagnoses included, but were not limited to: diabetes and hypertension. | R 0246 | **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>QMA 6 was re-educated on 3/19/2024 on the Indiana State rule to ensure prior authorization will be obtained before administering a PRN medication. QMA 6 was also re-educated on the appropriate documentation | 04/10/2024 |

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| | A Medication Administration Record (MAR), dated 12/2023, indicated Resident 3 was administered Tylenol 325 milligrams two tables, on 12/20/23 at 7:45 P.M. and 12/25/2023 at 7:15 P.M. by QMA 6.<br><br>No documentation in the MAR or the Nurse's Notes could be found that QMA 6 received prior authorization from a licensed nurse to give the as needed medication to Resident 3.<br><br>During an interview, on 3/19/2024 at 8:15 P.M., the Director of Nursing indicated she could not find any documentation in the medical record that QMA 6 received authorization to provide the as needed medications. Authorization should have been obtained to administer the Tylenol.<br><br>A policy was provided by the Director of Nursing, on 3/19/2024 at 10:32 A.M., titled, "Medication Administration Policy and & Procedures". The policy indicated, " ...The community will ensure that Residents are given their correct medication at the right time, in the right dosage per their physician's orders, and per state regulations ....:" | | procedure in nurses' notes identifying who the licensed nurse the QMA contacted for authorization was and when they were contacted.<br>**2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**<br>All residents have the potential to be affected by this deficient process. All medication passers were educated by DON on PRN standards or state rule. Any additional instances where a QMA did not obtain prior authorization before administering a PRN medication will be identified and the QMA will be re-educated on the Indiana State rule, in addition to re-education on the proper way to document the authorization in the nurses' notes.<br>**3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:**<br>The Director of Nursing (DON) was re-educated on 3/19/2024, by Regional Director of Nursing (RDN), and all medication passers were educated by DON on the Indiana State rule that QMAs are required to obtain prior authorization from a licensed nurse prior to administering a PRN medication. She was also | |

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| | | | re-educated on the documentation requirements for when and who the QMA obtained prior authorization from.<br>**4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.., what quality assurance program will be put into place:**<br>The Director of Nursing is responsible for sustained compliance. The DON/designee will complete audits by reviewing the MARs weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure all PRN medications administered by QMAs received prior authorization prior to administration. The audit willbe discussed at monthly IDT meetings. The ED will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.<br>**5 By what date will the systemic changes be completed?**<br>4/10/2024 | |
| R 0273<br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. | | | |
| | Based observation, record review, and interview, the facility failed to provide appropriate kitchen | R 0273 | **1 What corrective action(s) will be accomplished for those** | 04/10/2024 |

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| | sanitation, and dispose, date, and store foods appropriately in the main kitchen. This had the potential to affect all residents receiving food from the kitchen.<br><br>Findings include:<br><br>1. An initial kitchen observation tour was conducted on 3/18/2024 at 9:15 A.M. with the Dining Services Director. The following was observed:<br>a. The range/flattop grill, and oven was observed to have a brown substance on the backsplash and oven door of the unit. Dark, burnt appearing, long drips were observed down the side and the front of the unit.<br>b. The toaster was visibly soiled with splattered substances and food debris.<br>c. The stainless-steel prep table had debris on the lower shelf. The lower shelf had a plastic storage tub with the lid off the tub lying next to the tub. The plastic tub housed serving utensils and had debris in the bottom of the tub.<br>d. The plate holder was observed to have food debris along the bottom ledge of the unit.<br>e. The refrigerators had a tub of cantaloupe without a date for preparation or use by date, a plastic container of tomato sauce with a use date of 3/26/2024, and a plastic container of parmesan cheese with a use by date of 3/2/2024.<br>f. The freezers had an opened, unclosed, and undated bag of tater tots, and chicken breast.<br>g. The spice cabinet had ground cinnamon 15 ounces, ground black pepper 18 ounces, and thyme leaves 6 ounces, all without open dates.<br><br>2. On 3/19/2024 at 9:13 A.M., a follow up observation of the kitchen was completed. There was no change to the range/flattop grill and oven unit, no change to the toaster, and no change to | | **residents found to have been affected by the deficient practice:**<br>Dining Services Director and Cook were educated on the observed deficiencies on 3/19/2024. A deep clean of the kitchen was performed on 3/23/2023 to correct the identified deficiencies. All food in the refrigerators and freezers were assessed to ensure that proper dating procedures are followed. Any foods located without proper dating were disposed of.<br>**2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**<br>All residents had the potential to be affected by this deficiency. The Dining Services Director (DSD) and all dietary staff were educated on cleaning and storage procedures. The DSD will do regular audits of the kitchen to ensure cleanliness policies are maintained according to the Indiana Rule.<br>**3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:**<br>The DSD will provide ED with all cleaning procedure sign off forms to ensure cleaning procedures are being maintained properly. ED will | |

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| | the utensil storage tub. The lid to the tub was observed off the tub and lying next to the tub. The plate holder was observed to continue to have food debris along the bottom ledge of the unit.<br><br>During an interview, on 3/19/2024 at 9:16 A.M., the Dining Services Director indicated the kitchen had a schedule for cleaning with daily, weekly, and monthly tasks. She indicated there was a grease blockage at the grease trap, and the unit had been cleaned a month ago. The range, flattop, oven unit, toaster and prep table were wiped down daily. The utensil tub should have the lid placed on the tub.<br><br>During an interview, on 3/19/2024 at 9:21 A.M., the Dining Services Director indicated refrigerated leftovers were good for 3 days, including the days the leftovers were cooked and two additional days. Freezer items were used quickly, in general, usually around three days. Anything opened should be labeled, dated, and sealed, and the spices should have had received and open dates on the containers.<br><br>A Daily, Weekly, and Monthly Checklist was provided by the Dining Services Director on 3/19/2024 at 10:28 A.M. The Daily Cleaning List was dated 1/2/2024, initiated by an employee, and included tasks of cleaning flattop and wipe down oven, clean out toaster with tray as well, and empty grease trap. The Dining Services Director indicated this was the most current checklist she could find completed by the kitchen employees. The Weekly Cleaning List, dated 12/31/2023-1/6/2024, indicated to wipe down all cabinets in the kitchen. The Dining Services Director indicated this was the most current checklist she could find completed by the kitchen | | do regular audits of the kitchen to ensure proper cleaning standards, as well as proper dating and food storage procedures.<br>**4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.., what quality assurance program will be put into place:**<br>The Executive Director is responsible for sustained compliance. The DSD/designee will complete audits of the kitchen by reviewing cleaning and food storage procedures that are being followed weekly for 4 weeks, biweekly for 4 weeks, and monthly for 1 month. . Audits will be completed on rotating shifts and will take place during the week and on weekends. This will be reviewed weekly with by ED in weekly meeting with DSD. The audit willbe discussed at monthly IDT meetings. The ED will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.<br>**5 By what date will the systemic changes be completed?**<br>4/10/2024 | |

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| | employees. The Monthly Cleaning List, undated, indicated to deep clean stove, clean the wall behind stove, and clean outsides of all the kitchen equipment. There were no kitchen employee signed checklists provided.<br><br>A policy was provided on 3/19/2024 at 8:50 A.M. by the Dining Services Director titled, "Sanitizing Equipment and Food Contact Surfaces". The policy indicated, " ...1. Employees shall follow the sanitizing recommendations and procedures for each piece of equipment of food contact surface as discussed in the cleaning guideline and procedure for the specific piece of equipment, or per manufacturer's recommendations ...."<br><br>A policy was provided on 3/19/2024 at 8:50 A.M. by the Dining Services Director titled, "Date Marking". The policy indicated, " ...All food stored for more than 24 hours will be properly labeled according to the following guidelines ...2. Date marking for refrigerated storage food items ...Once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufacturer's expiration date ...3. Date marking for freezer storage food items ...Frozen food packages removed from the case will be dated with the date the item was received into the facility ...Once a package is opened, it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines or by the manufacturer's expiration date ...4. Prepared food or opened food items should be discarded when: The food item is leftover for more than 72 hours ...." | | | |
| R 0356<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(i)(1-8)<br>Clinical Records - Noncompliance<br>(i) A current emergency information file shall | | | |

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| | be immediately accessible for each resident, in case of emergency, that contains the following:<br>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.<br>(2) The resident ' s hospital preference.<br>(3) The name and phone number of any legally authorized representative.<br>(4) The name and phone number of the resident ' s physician of record.<br>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.<br>(6) Information on any known allergies.<br>(7) A photograph (for identification of the resident).<br>(8) Copy of advance directives, if available. | | | |
| | Based on record review and interview, the facility failed to ensure the emergency binder was complete and accurate, with all required resident information, for 1 out of 5 residents whose emergency information was reviewed. (Resident 7)<br><br>Finding includes:<br><br>A record review for Resident 7 was completed on 3/18/2024 at 1:30 P.M. Diagnoses included, but were not limited to: chronic kidney disease, depression, hypertension, and cardiomyopathy.<br><br>A review of the Emergency File binder indicated the records did not include the physician's name and phone number, or the resident's sex and age.<br><br>During an interview, on 3/18/2024 at 2:00 P.M., the Director of Nursing indicated she was not aware what was required in the emergency binder. | R 0356 | **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>On 3/19/2024 the Emergency binder was updated with the records from the EHR system to ensure that physician’s name and phone number, resident’s sex and age.<br>**2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**<br>All residents had the potential to be affected by this deficient practice. As such the DON printed off resident records from the EHR | 04/10/2024 |

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| | On 3/18/2024 at 9:50 A.M. the Administrator indicated they did not have a policy on emergency binders, they follow the regulations. | | system for all residents to ensure that the record fully encompassed all required information per the Indiana State rule.<br>**3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:**<br>The Executive Director (ED) and Director of Nursing (DON) were re-educated on 3/19/2024 on the Indiana State rule regarding what information is required to be in the resident files. DON or designee will ensure that upon admission the resident file has all required information and is printed out and added to the emergency binder upon admission.<br>**4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.., what quality assurance program will be put into place:**<br>The Executive Director is responsible for sustained compliance. The DON/designee will complete audits of the emergency binder weekly for 4 weeks, biweekly for 4 weeks, and monthly for 1 month to ensure that all required information is present in the resident file for each resident. The audit willbe discussed at monthly IDT meetings. The ED will determine if continued auditing is necessary based on 3 consecutive months of | |

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| | | | compliance. Monitoring will be on-going.<br>**5 By what date will the systemic changes be completed?**<br>4/10/2024 | |