

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2025	
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF EDISON LAKES		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 PARK PLACE, MISHAWAKA, , 46545					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00441067 and Complaint IN00452179. Complaint IN00441067- No deficiencies related to the allegations are cited. Complaint IN00452179- No deficiencies related to the allegations are cited. Survey date: January 28, 2025 Facility number: 013331 Residential Census: 81 Cedarhurst of Edison Lakes was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00441067 and Complaint IN00452179. Quality review completed January 30, 2025.	R 0000					

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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