STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF EDISON LAKES	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 a State Residential Licensure Survey. Survey dates: May 14 and 15, 2025 Facility number: 013331 Residential Census: 91 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed 5/23/2025	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency*	
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the	R 0117	**R 117 410 IAC 16.2-5-1.4(b) Personnel - Deficiency** **1. What**	06/30/2025

	twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a Cardiopulmonary Resuscitation (CPR) including first aid certified staff member working every shift for 2 of 7 days reviewed. (5/12 and 5/14) Finding includes: A nursing schedule, dated 5/8/2025 through 5/14/2025, indicated there were no CPR certified or first aid certified staff in the building on 5/12/2025 on		**corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** An audit took place on 5/30/2025 of staff charts to identify all staff members who did not hold a current CPR and first aid certification. Those staff members who were identified as not having current were informed and will be scheduled to attend future CPR classes held by the community. DON and ED will review the staffing schedule to ensure there is CPR and first aid coverage 24 hours a day. **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:** All residents had the potential to be affected by this deficient practice. DON and ED will review the staffing schedule to ensure there is CPR and first aid coverage 24 hours a day. CPR and first aid classes will be	

	third shift. On 5/14/2025, there were no first aide certified staff in the building on third shift. During an interview on 5/15/2025 at 11:16 A.M., the Director of Nursing indicated a staff member should always be in the building that has CPR and first aid certification. On 5/25/2025 at 1:03 P.M., the Director of Nursing indicated the facility did not have a policy regarding staff with CPR and first aid certification working requirements. Based on record review and interview, the facility failed to ensure a Cardiopulmonary Resuscitation (CPR) including first aid certified staff member working every shift for 2 of 7 days reviewed. (5/12 and 5/14) Finding includes: A nursing schedule, dated 5/8/2025 through 5/14/2025, indicated there were no CPR certified or first aid certified staff in the building on 5/12/2025 on third shift. On 5/14/2025, there were no first aide certified staff in the building on third shift. During an interview on 5/15/2025 at 11:16 A.M., the Director of Nursing indicated a staff member should always be in the building that has CPR and first aid certification.		held at the community for staff to get their certification. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** The Executive Director (ED) and Director of Nursing (DON) were re-educated on 5/29/25 on the Indiana State rule to meet the 24-hour scheduled and unscheduled needs of the residents and services. Current staff who are not CPR first aid certified will be scheduled for future classes held by the community. New staff will be screened upon hire to ensure their certifications are up to date. An up-to-date list will be kept with all the staff names who are current with their certifications to ensure 24-hour CPR first aid coverage. DON and/or ED will review the staffing schedule to ensure there is CPR and first aid coverage 24 hours a day. **4. How the**	

	On 5/25/2025 at 1:03 P.M., the Director of Nursing indicated the facility did not have a policy regarding staff with CPR and first aid certification working requirements.		**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:** The Executive Director is responsible for sustained compliance. The ED/designee will complete audits by reviewing the staffing schedule weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure there is 24-hour CPR first aid coverage. The audit willbe discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5. By what date will the systemic changes be completed?** June 28, 2025	
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using	R 0217	**R 4RR 217 410 IAC 16.2-5-2(e) (1-5) Evaluation - Deficiency**	06/30/2025

	appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 7 & 8 no longer reside in the facility. **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:** Complete chart audit performed on 5/30/2025 to verify that service plans have been signed by all parties. Any service plan found to have missing signatures were flagged for the DON to reach out and have the responsible parties sign the service plan. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:**	

R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (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 on observation, record review and interviews, the facility failed to ensure food was stored properly related to dating of opened food and removal of expired foods. This had a potential to affect 91 of 91 residents who consumed food from the kitchen. Finding includes: During an observation with the Dietary Services Supervisor (DSS) on 5/14/2025 at 9:50 A.M., the following items in the dry storage room were missing dates when received and/or opened: -ketchup, chocolate syrup, and canned peaches were missing a date when received -and an opened bag of lentils and an opened box of cornbread mix did not have an opened date During an observation with the DSS on 5/14/2025 at 10:00 A.M., the following items in the	R 0273	**R 273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services- Deficiency** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were found to have been affected by this deficient practice. The items were discarded immediately upon findings and labeled correctly. The Dinning Service Director (DSD) and dining staff has been re-educated on labeling and dating food items. **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:**	06/30/2025

	walk-in cooler were missing dates when received or opened, or were expired: -chocolate syrup not dated when opened, -a turkey breast not dated when received, -a bottle of Grey Poupon mustard that expired on 3/2025 -a bag of hamburger buns that expired on 3/2025. The buns were touching the cooling unit, which was dusty. During an interview on 5/14/2025 at 10:15 A.M., the DSS indicated the food should have been dated when received and when opened and food should not be stored near the cooling unit. On 5/15/2025 at 11:40 A.M. the ED provided a current, undated policy titled, "Food Storage Policy and Procedure." The policy indicated, " ...Food Service Director will inspect and ensure that all opened foods are properly dated and stored daily ...." Based on observation, record review and interviews, the facility failed to ensure food was stored properly related to dating of opened food and removal of expired foods. This had a potential to affect 91 of 91 residents who consumed food		All residents have the potential to be affected by this deficient practice. A complete food audit was performed on 6/30/2025 to verify that all food items have a received and opened label date. **3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur:** DSD/ED will complete regular audits to ensure food is properly labeled. **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:** The Executive Director is responsible for sustained compliance. The ED/ Designee will review audit biweekly for 4 weeks, then monthly for 1 month to ensure proper labeling of food. The audit willbe discussed at monthly QI	

	from the kitchen. Finding includes: During an observation with the Dietary Services Supervisor (DSS) on 5/14/2025 at 9:50 A.M., the following items in the dry storage room were missing dates when received and/or opened: -ketchup, chocolate syrup, and canned peaches were missing a date when received -and an opened bag of lentils and an opened box of cornbread mix did not have an opened date During an observation with the DSS on 5/14/2025 at 10:00 A.M., the following items in the walk-in cooler were missing dates when received or opened, or were expired: -chocolate syrup not dated when opened, -a turkey breast not dated when received, -a bottle of Grey Poupon mustard that expired on 3/2025 -a bag of hamburger buns that expired on 3/2025. The buns were touching the cooling unit, which was dusty. During an interview on 5/14/2025 at 10:15 A.M., the		meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5. By what date will the systemic changes be completed?** June 30, 2025	

	DSS indicated the food should have been dated when received and when opened and food should not be stored near the cooling unit. On 5/15/2025 at 11:40 A.M. the ED provided a current, undated policy titled, "Food Storage Policy and Procedure." The policy indicated, " ...Food Service Director will inspect and ensure that all opened foods are properly dated and stored daily ...."			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d) (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview the facility failed to obtain an Annual Health Statement that indicated the resident was free of communicable disease including tuberculosis (TB) in an infectious state for 1 of 7 residents reviewed for Annual Health Statements. (Resident 7) Finding includes:	R 0409	**R 409 410 IAC 16.2-5-12 (d)Infection Control Noncompliance** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 7 no longer reside in the facility. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice**	06/28/2025

Resident 7's record review was completed on 5/14/2025 at 11:00 A.M. Diagnoses included but were not limited to: essential primary hypertension.

The most recent Annual Health statement for Resident 7 was dated 6/13/2023.

During an interview on 5/15/2025 at 11:45 A.M., the DON indicated there had been no other Annual Health Statements obtained for Resident 7.

On 5/15/2025 at 1:20 P.M. a current policy dated 9/18/2024 and titled, "Assessment (IN) Policy and Procedures." The policy indicated, " ...Residents shall be assessed by a physician within 120 days prior to moving into the community and on an annual basis with the Physician's Assessment, History & Physical and Certification Form [500-119]. A new Physician's Assessment should be completed with any noted significant change ...."

Based on record review and interview the facility failed to obtain an Annual Health Statement that indicated the resident was free of communicable disease including tuberculosis (TB) in an infectious state for 1 of 7 residents reviewed for Annual Health Statements. (Resident 7)

and what corrective action will be taken:

Complete chart audit performed on 5/30/2025 to verify each resident
has an annual health assessment completed by physician. Any resident found to have a missing annual health assessment were flagged for the DON/designee to
reach out to the resident physician.

**3. What measure will be put into place or what systemic changes the facility will make to
ensure that the deficient practice does not reoccur:**

DON and ED will review charts bi-weekly to ensure all residents have a
completed annual health assessment in the chart per policy.

**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:**

	Finding includes: Resident 7's record review was completed on 5/14/2025 at 11:00 A.M. Diagnoses included but were not limited to: essential primary hypertension. The most recent Annual Health statement for Resident 7 was dated 6/13/2023. During an interview on 5/15/2025 at 11:45 A.M., the DON indicated there had been no other Annual Health Statements obtained for Resident 7. On 5/15/2025 at 1:20 P.M. a current policy dated 9/18/2024 and titled, "Assessment (IN) Policy and Procedures." The policy indicated, " ...Residents shall be assessed by a physician within 120 days prior to moving into the community and on an annual basis with the Physician's Assessment, History & Physical and Certification Form [500-119]. A new Physician's Assessment should be completed with any noted significant change ...."		The Executive Director is responsible for sustained compliance. The ED/designee will complete audits by reviewing 3 charts weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure resident charts contain an annual health assessment. The audit willbe discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5. By what date will the systemic changes be completed?** June 28, 2025	

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