STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF EDISON LAKES	1025 PARK PLACE MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	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 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency 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.	R 0117	**R 117 410 IAC 16.2-5-1.4(b) Personnel - Deficiency** **1. What 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	06/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy DeMeester	Executive Director	06/04/2025

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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	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.		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 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	

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			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 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	

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R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to update service plans timely for 2 of 7 residents reviewed for service plans. (Resident 7 & 8) Findings include: 1. 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. Resident 7's most recent Service Plan was dated 6/8/2023. The Service Plan did not have the resident's signature and had not been updated. During an interview on 5/15/2025 at 11:45 A.M., the DON indicated Resident 7's Service Plan was not updated or signed by the resident. 2. The record for Resident 8 was reviewed on 5/15/2025 at 11:31 A.M. The resident's diagnoses included, but were no limited to: diabetes mellitus, depression, anxiety, chronic embolism and thrombosis of unspecified deep veins of distal lower extremity, rheumatoid arthritis, lymphedema and obstructive sleep apnea. A Service Plan, dated 9/30/2024, for Resident 8 was completed but did not have a signature from Resident 8 or a legal representative. During an interview, on 5/15/2025 at 1:05 P.M., the Director of Nursing (DON) indicated the service plan for Resident 8 was completed but not signed by the resident. The DON indicated the service plan should have been signed by the resident.	R 0217	**R 4RR 217 410 IAC 16.2-5-2(e) (1-5) Evaluation - Deficiency** **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:** DON and ED will review charts bi-weekly to ensure all service plans have been signed by all responsible parties per policy. **4. How the corrective action(s) will be monitored to ensure the**	06/30/2025

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	On 5/15/2025 at 1:08 P.M., the DON provided a policy titled, "Individualized Service Plan," undated and indicated the policy was the one currently used by the facility. The policy indicated " ...The Individualized Service Plan will be developed and mutually agreed upon within 14 days after move-in, unless otherwise specified, based on all the information gathered during the assessment process by the Community and the Resident and/or the Resident's Authorized Signer..."		**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 3 charts weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure care plans are signed. 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 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency 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:	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	06/30/2025

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	-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 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 ...."		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:** 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	

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			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 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	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance 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: 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.	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 and what corrective action will be taken:** Complete chart audit performed on 5/30/2025 to verify each resident has an annual health assessment	06/28/2025

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	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 ...."		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:** 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**	

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			systemic changes be completed? June 28, 2025	