PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | E SURVEY PLETED 9/2024 | |
|--|--|---|--------|--|--|------------------------------|--|
| | PROVIDER OR SUPPLIE | | 10 | TREET ADDRESS, CITY, STATE, ZIP 025 PARK PLACE IISHAWAKA, IN 46545 | COD | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | | | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION | CROSS-REFERENCED TO THE APPROPRIATE | | |
| R 0000 | | | | | | | |
| Bldg. 00 | This visit was for a State Residential Licensure Survey. | | R 0000 | | | | |
| | Survey dates: June | 18 and 19, 2024 | | | | | |
| | Facility number: 01 | 13331 | | | | | |
| | Residential Census: 77 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. | | | | | | |
| | | | | | | | |
| | Quality Review con | mpleted on 6/21/2024 | | | | | |
| R 0120 | 410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance | | | | | Ì | |
| Bldg. 00 | failed to ensure the training had been chire for 1 of 5 empiration. (Qualified Finding includes: An employee recore 6/19/2024 at 11:10 Medication Aide) 37/3/2023. The employeementation to in required 6 hours of hired employees. During an interview Executive Director | view and interview, the facility required 6 hours of dementia ompleted within six months of loyees reviewed for dementia d Medication Aide 3) d review was completed on A.M for QMA (Qualified B. QMA 3 was hired on loyee file lacked the indicate she had completed the dementia training for newly a completed QMA 3 had not urs of dementia training. He | R 0120 | R 120 410 IAC 16.2-5 Personnel – Deficient (e) There shall be an in-service education a program planned in advance for all person departments at least a Training shall include limited to, residents' r prevention and control fire prevention, safety prevention, the needs specialized population medication administration nursing care, when appropriat (1) The frequency and in-service education and training shall be in accordance. | organized and training annually. , but is not ights, ol of infection, or, accident as of a served, ation, and te, as follows: d content of g programs | 07/05/2024 | |

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

TITLE

(X6) DATE

Amy Borzymowski

Regional Director of Operations

07/05/2024

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.

State Form Event ID: OYCM11 Facility ID: 013331 If continuation sheet Page 1 of 8

PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. BUILDING 00 COMPLETED B. WING 06/19/2024 | | | | | | |
|--|--|--|--|--|--|--|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 1025 PARK PLACE MISHAWAKA, IN 46545 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | dementia training ar guidelines for deme Administrator indic | r did not have a policy for and followed the state intia training requirements. The ated there were some residents residing in the building. | | skills and knowledge of the facility personnel. For nursing personnel, this shall include a least eight (8) hours of in-serv per calendar year and four (4) hours of in-service per calend year for non-nursing personne (2) In addition to the above required in service hours, staff have contact with residents shave a minimum of six (6) hou dementia-specific training with six (6) months and three (3) hours annually thereafter to meet the needs of preferences, or both, of cognit impaired residents effectively to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate following: (A) The time, date, shocation. (B) The name of the instructor. (D) names of the participants. (E) program content of in-service. employee will acknowledge attendance by written signature. 1. What corrective action(s) the accomplished for those residents found to have been affected by the deficient practice: An audit took place on 7-2-24 staff charts to identify all staff members who had not complete with an audit took place on 7-2-24 staff charts to identify all staff members who had not complete with a not complete with an audit took place on 7-2-24 staff charts to identify all staff members who had not complete with a not complete with an audit took place on 7-2-24 staff charts to identify all staff members who had not complete who are staff to the process of the participants. | t rice of ar el. f who hall curs of hin or tively and the and or the or the ore will or the ore will or the ore will or the ore will or the ore or the ore will or the ore or the ore will or the ore | | | |

State Form Event ID: OYCM11 Facility ID: 013331 If continuation sheet Page 2 of 8

PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | COM | e survey pleted 9/2024 |
|--------------------------|----------------------------------|---|--|--|---|------------------------------|
| | ROVIDER OR SUPPLIE | | 1025 P | ADDRESS, CITY, STATE, ZIP ARK PLACE WAKA, IN 46545 | COD | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY) | ORRECTION SHOULD BE APPROPRIATE | (X5) COMPLETION DATE |
| | | | | 6 hours of dementia to 6 months of hire. Those members who were in not trained were informable scheduled to attentraining curriculum on 2. How the facility wing other residents having potential to be affect same deficient practice what corrective action taken: All residents had the properties and AEI all newly hired staff where scheduled for 6 hours training within their firms of employment. 3. What measure will into place or what synchanges the facility who to ensure that the depractice does not recovered to the properties of the monitories of a maintain a record of a employees to include onboarding tasks, trainer training to the corrective will be monitored to deficient practice will recur, i.e., what qualities assurance program with the place: The Executive Director Assistant Executive Director in the place in the properties of the properties of the properties of the properties will be monitored to the properties of the properties will be monitored to the properties of the properties will be monitored to the properties of the properti | se staff dentified as med and will dementia line. Ill identify ng the sed by the ice and on will be potential to ficient D will ensure ill be sof dementia at 6 months I be put estemic will make efficient occur: se scheduled during their AED will all new their ening, and se action(s) ensure the li not ity will be put | |

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PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION (X3) DATE SURVEY OO COMPLETED 06/19/2024 | | |
|---|--|--|--|--|-----------------------------------|
| | ROVIDER OR SUPPLIER | | 1025 P | ADDRESS, CITY, STATE, ZIP COD ARK PLACE WAKA, IN 46545 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | meet weekly to review all new hires and due dates. Monitoring will be on-going. 5. By what date will the systemic changes be completed? July 5, 2024 | |
| R 0144 | 410 IAC 16.2-5-1.5 Sanitation and Sat | • • | | | |
| Bldg. 00 | Based on observation and interview the facility failed to maintain the facility in a state of cleanliness and good repair on 7 of 7 residental halls. (Hall 101-116, 117-130, 131-146, 147-160, 201-216, 217-230 and 231-246) Finding includes: During an observation of the building on 6/18/24 at 9:45 A.M., the following concerns were noted: Hall 101-116 -The carpet in the hallway was dirty and stained in several areas. -The resident apartment doors and hallway walls were dirty and had black scuff marks. Hall 117-130 -The resident apartment doors were dirty and had scuff marks. -The carpet in the hallway was stained in several places. -The handrails in the hallways had areas where the paint was scraped. Hall 201-216 -The handrails in the hallway had areas where the paint was scraped. -The resident apartment doors and walls in the hallway were dirty and had black scuff marks. | | R 0144 | R 144 410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards – Deficiency (a. The facility shall be clean, orderly and in a state of good repair, both inside and cand shall provide reasonable comfort for all residents. 1. What corrective action(s) be accomplished for those residents found to have bee affected by the deficient practice: No resident was found to have been affected by this deficient practice. 2. How the facility will identiful other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: No residents were found to be affected by the deficient practice and what corrective action will be taken: No residents were found to be affected by the deficient practice and what corrective action will be taken: No residents were found to be affected by the deficient practice and what corrective action will be taken: All 17-130, 131-147-160, 201-216, 217-230 and 231-246 were immediately addressed. Carpets in every resident hallway have been deficient practice. | will n e t fy ne e cice. 146, nd |

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) D. | | (X3) DATE | 3) DATE SURVEY | | | |
|---------------------------|---|----------------------------------|------------------------------------|-----------------|--|----------------|-------|--|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED | | |
| | | | B. W | ING | | 06/19/ | /2024 | | |
| | | <u> </u> | 1 | CTDEET / | ADDRESS, CITY, STATE, ZIP COD | | | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | | | | | |
| CEDADI | ILIDOT OF EDICON | II VKES | | 1025 PARK PLACE | | | | | |
| CEDARF | IURST OF EDISON | N LANES | | IVIISHA | WAKA, IN 46545 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CO | | | | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | 1 | TAG | DEFICIENCY | | DATE | | |
| | Hall 217-230 | | | | cleaned, shampooed and stea | ım | | | |
| | -The hallway carpe | t was stained in several places. | | | sanitized. All resident hallways | 5, | | | |
| | -The electrical room | n door was ajar. | | | walls, common area walkways | 3 | | | |
| | | | | | and elevators were repainted. | | | | |
| | Hall 131-146 | | | | 3. What measure will be put | | | | |
| | _ | s were noted on the carpet in | | | into place or what systemic | | | | |
| | the hallway. | | | | changes the facility will make | е | | | |
| | | ment doors and the hallway | | | to ensure that the deficient | | | | |
| | l - | d had black scuff marks. | | | practice does not reoccur: | | | | |
| | | noted on multiple ceiling tiles | | | | | | | |
| | in the hallway. | | | | The Executive Director will en | sure | | | |
| | | | | | that the Cedarhurst Environme | | | | |
| | Hall 147-160 | | | | Quality Standards document v | vill | | | |
| | _ | ment doors and hallway walls | | | be followed and that all | | | | |
| | were dirty and had | | | | preventative maintenance in tl | he | | | |
| | | ne hallway had areas where the | | | community will be completed i | n a | | | |
| | paint was scraped. | | | | timely fashion. The communit | :y | | | |
| | -The hallway carpe | t was stained in several places. | | | will use the TELS system to e | nter | | | |
| | | | | | and track any areas of the | | | | |
| | Hall 231-246 | | | | community that need cleaning | or | | | |
| | -The handrails in the paint was scraped. | ne hallway had areas where the | | | repair. | | | | |
| | -The electrical room | n door was ajar and would not | | | 4. How the corrective action(| (s) | | | |
| | latch. | | | | will be monitored to ensure t | :he | | | |
| | | | | | deficient practice will not | | | | |
| | _ | v on 6/18/24 at 9:57 A.M., CNA | | | recur, i.e., what quality | | | | |
| | 2 indicated the elec | trical doors should always be | | | assurance program will be p | ut | | | |
| | closed and locked. | | | | into place: | | | | |
| | During a tour of the | e facility and interview on | | | The Executive Director is | | | | |
| | | A., with Environmental Services | | | responsible for sustained | | | | |
| | | | | | compliance. The Executive | | | | |
| | Director, he indicated the carpets, walls, and doors were dirty, and the handrails were missing | | | | Director/designee and the | | | | |
| | paint. He indicated he had only been employed at | | | | Environmental Services Direct | tor | | | |
| | _ | onth and had not had time to | | | will complete weekly audits of | | | | |
| | | and maintenance tasks | | | community to ensure cleanline | | | | |
| | | hedule, but was aware of the | | | and upkeep of the community. | | | | |
| | | e indicated carpet cleaning | | | The audit willbe discussed at | | | | |
| | _ | edule but would be added. | | | | | | | |
| | was not on the sche | duie out would be added. | | | weekly leadership meetings. Monitoring will be on-going. | | | | |
| I | l | | 1 | | i ivioriiloriria wiii de on-aoina. | | Ī | | |

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| STATEMENT OF DEFICIENCIES X | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV | | SURVEY | | | | |
|-----------------------------|--|---|---|----------------------------------|---|----------|------------|--|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | COMPLETED | | |
| | | | B. W | ING | | 06/19/ | /2024 | | |
| | | | | STREET . | ADDRESS, CITY, STATE, ZIP COD | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 1025 PARK PLACE | | | | | |
| | IURST OF EDISON | LAKES | MISHAWAKA, IN 46545 | | | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) | | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | | | |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | | | DATE | | |
| | | P.M. the Regional Director of d a document titled, "Quality | | | 5. By what date will the | | | | |
| | | icated they did not have a | | | systemic changes be completed? | | | | |
| | | the guidelines in that | | | July 5, 2024 | | | | |
| | | ument indicated, "Doors and | | | July 3, 2024 | | | | |
| | | tches, damage or discoloratoin | | | | | | | |
| | including settlemen | ~ | | | | | | | |
| | men gomernen | | | | | | | | |
| R 0273 | 410 IAC 16.2-5-5. | 1(f) | | | | | | | |
| | | nal Services - Deficiency | | | | | | | |
| Bldg. 00 | | - | | | | | | | |
| | Based on observation, interview and record review, the facility failed to ensure food was stored and prepared in a sanitary manner and failed to ensure food was labeled and dated in 1 of | | R 0 | 273 | R 273 410 IAC 16.2-5-5.1(f) F | ood | 07/05/2024 | | |
| | | | | | and Nutritional Services – | | | | |
| | | | | | Deficiency | | | | |
| | | | | | (f) All food preparation and se | rving | | | |
| | | I. This had the potential to | | | areas (excluding areas in | | | | |
| | | ts who received food from the | | | residents ' units) are maintaine | ed in | | | |
| | kitchen. | | | | accordance with state and loc | | | | |
| | | | | | sanitation and safe food hand | ling | | | |
| | Finding includes: | | | | standards, | | | | |
| | 0 (110/2020 + 0.1 | 0.435 (0.1.17.1 | | | including 410 IAC 7-24. | | | | |
| | | 0 A.M. a tour of the kitchen | | | | | | | |
| | _ | the Director of Dining (DOD). | | | 1.What corrective action(s) v | VIII | | | |
| | The following was | observed: | | | be accomplished for those | _ | | | |
| | I area amount of t | rash and food debris were | | | residents found to have been | n | | | |
| | _ | table in the center of the | | | affected by the deficient | | | | |
| | kitchen. | table in the center of the | | | practice: | | | | |
| | | of dust was on the ceiling tiles | | | No residents were found to be | <u>,</u> | | | |
| | | bove the main food prep | | | affected by the deficient practi | | | | |
| | station. | co. 2 die main rood prop | | | and the deficient practi | | | | |
| | | of black grime and grease | | | | | | | |
| | | s steel table connected to the | | | 2. How the facility will identif | fv | | | |
| | | in dishwashing area. | | | other residents having the | , | | | |
| | • | stance covered the entire | | | potential to be affected by the | ie | | | |
| | | gasket of the walk-in cooler. | | | same deficient practice and | | | | |
| | - | stance covered half of the | | | what corrective action will be | е | | | |
| | | gasket of the walk-in freezer. | | | taken: | | | | |
| | | opened, unsealed and undated | | | All residents had the potentia | l to | | | |
| | on food prep table. | | | | be affected by the deficient | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 06/19/2024 | |
|---|--|--|---------------------|--|--|
| NAME OF I | PROVIDER OR SUPPLIEF | | | ADDRESS, CITY, STATE, ZIP COD | |
| CEDAR | HURST OF EDISON | LAKES | | WAKA, 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 CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ON (X5) DE COMPLETION DATE |
| | During an interview DOD confirmed the the food prep statio ceiling and vent, a like mold on the gas freezer, a build up of connected to the discroutons and corn fidate. During an interview 1:54 P.M., she indictabel and dating operite of the discroutons and corn fidate. On 6/19/2024 at 1:55 blank, undated check the cloth of the check by the facility. The following: "Daily coolers and freezer. | s opened and undated in dry of on 6/19/2024 at 9:30 A.M., the cre was food and trash under in, dust collecting on the black substance that looked skets of the walk-in cooler and of grease on the table sh sink, and the opened lakes were not labeled with a with the DOD, on 6/19/2024 at cated there was no policy for ened food or maintaining a indicated the facility used monthly cleaning check lists to can. 64 P.M., the DOD provided a chlist titled, "Kitchen Duties on Person". The DOD list as the one currently used checklist included the politiesClean all doors to theSweep and mop under preperperperperperperperperperperperperp | | practices found. All containers were immed labeled. Storage areas were deeply cleaned and reorgat Walk in refrigeration doorwareceived new seals. Kitcher equipment in food prepares sanitized and repairs or replacements of older equipmere completed. 3. What measure will be printo place or what system changes the facility will not one sure that the deficient practice does not reoccur. The Regional Director of Discruices has implemented Kitchen Inspection Reading Checklist, The Opening/Clecklist, The Opening/Clecklist and the Daily and Weekly Cleaning Checklist dining services employees been trained in the above-mentioned procedure documentation requirement. 4. How the corrective active will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place: The Executive Director is responsible for sustained compliance. The Executive Director/designee and the Services Director or design | re unized. vays en eas was spment but hic hake nt r: bining the ess osing d t. All have res and hts. fon(s) re the Dining |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 06/19/2024 | |
|--|----------------|---|--|-----------------|--|---------------------------------------|------------|
| NAME OF PROVIDER OR SUPPLIER CEDARHURST OF EDISON LAKES | | | STREET ADDRESS, CITY, STATE, ZIP COD 1025 PARK PLACE MISHAWAKA, IN 46545 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG DEFICIENCY) | | | DATE |
| | | | | | complete daily audits of the kitchen to ensure cleanliness a upkeep of the community for 2 weeks. After 2 weeks the aud will be completed weekly. The audit willbe discussed at week leadership meetings. Monitori will be on-going. 5. By what date will the systemic changes be completed? July 5, 2024 | 2 lits e kly | |

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