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	06/19/2024

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: June 18 and 19, 2024 Facility number: 013331 Residential Census: 77 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 6/21/2024	R 0000		
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure the required 6 hours of dementia training had been completed within six months of hire for 1 of 5 employees reviewed for dementia training. (Qualified Medication Aide 3) Finding includes: An employee record review was completed on 6/19/2024 at 11:10 A.M for QMA (Qualified Medication Aide) 3. QMA 3 was hired on 7/3/2023. The employee file lacked the documentation to indicate she had completed the required 6 hours of dementia training for newly hired employees. During an interview on 6/19/2024 at 3:15 P.M., the Executive Director indicated QMA 3 had not completed the 6 hours of dementia training. He	R 0120	**R 120 410 IAC 16.2-5-1.4(e) (1-3) Personnel – Deficiency** (e) There shall be an organized in-service education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of in-service education and training programs shall be in accordance with the	07/05/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Borzymowski	Regional Director of Operations	07/05/2024

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	indicated the facility did not have a policy for dementia training and followed the state guidelines for dementia training requirements. The Administrator indicated there were some residents with early dementia residing in the building.		skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of in-service per calendar year and four (4) hours of in-service per calendar year for non-nursing personnel. (2) In addition to the above required in service hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of in-service. The employee will acknowledge attendance by written signature **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 7-2-24 of staff charts to identify all staff members who had not completed	

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			6 hours of dementia training within 6 months of hire. Those staff members who were identified as not trained were informed and will be scheduled to attend dementia training curriculum online. **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. ED and AED will ensure all newly hired staff will be scheduled for 6 hours of dementia training within their first 6 months of employment. **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:** New employees will be scheduled for dementia training during their orientation. ED and AED will maintain a record of all new employees to include their onboarding tasks, training, and certification due dates. **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 and Assistant Executive Director will	

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			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 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency 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 out, and shall provide reasonable comfort for all residents. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No resident was found to have been affected by this deficient practice. **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:** No residents were found to be affected by the deficient practice. Halls 101-116, 117-130, 131-146, 147-160, 201-216, 217-230 and 231-246 were immediately addressed. Carpets in every resident hallway have been deep	07/05/2024

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	Hall 217-230 -The hallway carpet was stained in several places. -The electrical room door was ajar. Hall 131-146 -Several large stains were noted on the carpet in the hallway. -The resident apartment doors and the hallway walls were dirty and had black scuff marks. -Water stains were noted on multiple ceiling tiles in the hallway. Hall 147-160 -The resident apartment doors and hallway walls were dirty and had black scuff marks. -The handrails in the hallway had areas where the paint was scraped. -The hallway carpet was stained in several places. Hall 231-246 -The handrails in the hallway had areas where the paint was scraped. -The electrical room door was ajar and would not latch. During an interview on 6/18/24 at 9:57 A.M., CNA 2 indicated the electrical doors should always be closed and locked. During a tour of the facility and interview on 6/19/24 at 9:43 A.M., with Environmental Services Director, he indicated the carpets, walls, and doors were dirty, and the handrails were missing paint. He indicated he had only been employed at the facility for a month and had not had time to complete cleaning and maintenance tasks according to the schedule, but was aware of the issues presented. He indicated carpet cleaning was not on the schedule but would be added.		cleaned, shampooed and steam sanitized. All resident hallways, walls, common area walkways and elevators were repainted. **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 will ensure that the Cedarhurst Environmental Quality Standards document will be followed and that all preventative maintenance in the community will be completed in a timely fashion. The community will use the TELS system to enter and track any areas of the community that need cleaning or repair. **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 Executive Director/designee and the Environmental Services Director will complete weekly audits of the community to ensure cleanliness and upkeep of the community. The audit willbe discussed at weekly leadership meetings. Monitoring will be on-going.	

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	On 6/19/24 at 2:33 P.M. the Regional Director of Operations provided a document titled, "Quality Standards." She indicated they did not have a policy but followed the guidelines in that document. The document indicated, "...Doors and walls free from scratches, damage or discoloratoin including settlement cracks...."		**5. By what date will the systemic changes be completed?** July 5, 2024	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency 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 1 kitchens reviewed. This had the potential to affect all 77 residents who received food from the kitchen. Finding includes: On 6/19/2020 at 9:10 A.M. a tour of the kitchen was completed with the Director of Dining (DOD). The following was observed: - Large amount of trash and food debris were under the food prep table in the center of the kitchen. - A heavy build up of dust was on the ceiling tiles and vents directly above the main food prep station. - A heavy build up of black grime and grease covered the stainless steel table connected to the 3 compartment sink in dishwashing area. - A black fuzzy substance covered the entire length of the rubber gasket of the walk-in cooler. - A black fuzzy substance covered half of the length of the rubber gasket of the walk-in freezer. -1 bag of croutons, opened, unsealed and undated on food prep table.	R 0273	**R 273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services – Deficiency** (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. **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 be affected by the deficient practice. **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 the deficient	07/05/2024

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	-1 box of cereal was opened and undated in dry storage room. During an interview on 6/19/2024 at 9:30 A.M., the DOD confirmed there was food and trash under the food prep station, dust collecting on the ceiling and vent, a black substance that looked like mold on the gaskets of the walk-in cooler and freezer, a build up of grease on the table connected to the dish sink, and the opened croutons and corn flakes were not labeled with a date. During an interview with the DOD, on 6/19/2024 at 1:54 P.M., she indicated there was no policy for label and dating opened food or maintaining a clean kitchen. She indicated the facility used daily, weekly, and monthly cleaning check lists to keep the kitchen clean. On 6/19/2024 at 1:54 P.M., the DOD provided a blank, undated checklist titled, "Kitchen Duties Cooks and Sanitation Person". The DOD identified the checklist as the one currently used by the facility. The checklist included the following: "...Daily Duties...Clean all doors to the coolers and freezer...Sweep and mop under prep table... Clean out prep coolers including gaskets...."		practices found. All containers were immediately labeled. Storage areas were deeply cleaned and reorganized. Walk in refrigeration doorways received new seals. Kitchen equipment in food prep areas was sanitized and repairs or replacements of older equipment were completed. **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 Regional Director of Dining Services has implemented the Kitchen Inspection Readiness Checklist, The Opening/Closing Checklist and the Daily and Weekly Cleaning Checklist. All dining services employees have been trained in the above-mentioned procedures and documentation requirements. **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 Executive Director/designee and the Dining Services Director or designee will	

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			complete daily audits of the kitchen to ensure cleanliness and upkeep of the community for 2 weeks. After 2 weeks the audits will be completed weekly. The audit willbe discussed at weekly leadership meetings. Monitoring will be on-going. **5. By what date will the systemic changes be completed?** July 5, 2024	