STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/18/2026

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: September 17 and 18, 2026 Facility number: 013331 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 10/01//2026	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 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s	R 0243	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	

	medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, interview, and record review, the facility failed to ensure a medication was administered in accordance with physician orders and medication administration standards for 1 of 5 residents observed during medication administration. (Resident 9) Findings include: During a medication administration observation, conducted on 9/17/2026 at 9:50 A.M. with QMA 2, she was observed preparing to crush a 650 mg enteric-coated Tylenol tablet for administration to Resident 9. The QMA was prevented from administering the crushed medication to Resident 9.		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:** All residents had the potential to be affected by this deficient practice. All QMA and nurses have been re-educated on 10/1/26 an audit took place of to identify any resident who receives and enteric coated tablet that it will not be crushed. **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 DON or designee will enter a DO NOT CRUSH note to the medication pass for those residents who receive enteric coated tablet and have an order to crush medications. **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:**	

	During an interview on 9/17/2026 at 9:50 A.M., QMA 2 indicated she had always crushed Resident 9's medications, including the enteric coated Tylenol. The facility provided a policy titled, "Medication Administration Policy and Procedures," dated 9/27/2024, indicated, " ...The community will ensure that residents are given their correct medication at the right time, in the right dosage per their physician's orders, per state regulations ...." The policy did not specifically address crushing medications. According to the Long Term Care Advisory ERR, published April 2017, Volume 5, Issue 4, "According to the Institute for Safe Medication Practices (ISMP), enteric-coated tablets should not be crushed or split because doing so may release the medication in the stomach, where it may be broken down, not absorbed, or cause gastrointestinal irritation."		The ED/designee will complete audits by reviewing medication orders weekly for 4 weeks, biweekly for 4 weeks, then monthly for 1 month to ensure a DO NOT CRUSH note is entered for those residents who receive enteric coated tablet and has an order to crush medications. The audit will be discussed at monthly QI meetings **5. By what date will the systemic changes be completed?** 10/15/26	
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	R 0273	**1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	

	sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to serve food in a sanitary manner in 1 of 1 dining rooms. This potentially affected 100 of 100 residents served in the dining room. Finding includes: During an observation of lunch service on 9/17/2026 at 11:57 A.M., 3 staff members, Employees 3, 4 and 5, were serving the meal. The staff members were serving plated food with their thumbs on the eating surface of the plates and holding drinking glasses by the rim on the drinking surface while they were filling and serving the drinks. On 9/18/2026 at 12:03 P.M. the ED indicated staff should not have been touching the eating and drinking surfaces of plates and cups. She also indicated the facility did not have a policy regarding serving of food and drinks in the dining room.		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:** All residents had the potential to be affected by this deficient practice. On 9/28/26 all dietary staff were reeducated on the correct procedure for handling plates and glassware . **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:** All staff upon hire and ongoing will receive job specific training on proper handling of plates and glassware. **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:** ED or designee will monitor meal service 1 time daily for 4 weeks on proper handling of plates and glassware. and then 1x weekly for 4 weeks and then	

			monthly for 4 months and then monitoring will be on going. **5. By what date will the systemic changes be completed?** 10/15/26	
R 0412	Infection Control - Noncompliance 410 IAC 16.2-5-12(i) (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility failed to assess residents annually for tuberculosis (TB). for 2 of 7 residents reviewed. (Residents 6 and 9) Findings include: 1. A record review for Resident 6 was completed on 9/17/2026 at 1:15 P.M. There was no annual TB skin test or	R 0412	1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 6 & 8 who were identified as not having current or annual TB skin test or assessment were informed and received a TB skin test. 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. An audit was completed on 10/7/26 of all resident charts to identify any resident who did not have a current annual TB test or screening. Those residents who were	

	assessment completed in the previous 12 months. 2. A record review for Resident 8 was completed on 9/17/2026 at 2:10 P.M. There was no annual TB skin test or assessment was completed in the past 12 months. During an interview on 9/18/2026 at 9:24 A.M. the ED indicated the annual TB testing's had not been completed. A policy for TB testing was requested on 9/18/2026 but none was not provided prior to the survey exit.		identified as not having current Tb test or screening were informed and will receive a TB screen or test. 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 DON or designee will create a tracker. Residents will be added to the tracker upon admission to the community and will verify through emar system that a QuantiFERON gold blood test, TB test and or screen has been completed for each resident. 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 or designee will review the tracker 1x monthly for 6 months to verify new residents received	

			QuantiFERON gold blood test or 2 step TB test upon admission. The tracker will be discussed at monthly QI meetings 5. **By what date will the systemic changes be completed?** 10/15/26	

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 SIGNATUREStacy DeMeester	TITLEExecutive Director	(X6) DATE10/12/2026