

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013331	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/28/2025
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NAME OF PROVIDER OR SUPPLIER CEDARHURST OF EDISON LAKES	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 PARK PLACE MISHAWAKA, IN 46545
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00441067 and Complaint IN00452179.</p> <p>Complaint IN00441067- No deficiencies related to the allegations are cited.</p> <p>Complaint IN00452179- No deficiencies related to the allegations are cited.</p> <p>Survey date: January 28, 2025</p> <p>Facility number: 013331</p> <p>Residential Census: 81</p> <p>Cedarhurst of Edison Lakes was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00441067 and Complaint IN00452179.</p> <p>Quality review completed January 30, 2025.</p>	R 000		

Indiana Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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