STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155066	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewater Woods	1809 N Madison Ave Anderson, IN 46011

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide residents and/or their representatives with written notice of transfer/discharge and bed hold policy for 1 of 3 residents reviewed for hospitalizations. (Resident 78)Resident 78's record was reviewed on 4/15/126 at 3:51 p.m. Diagnoses included liver cancer, altered mental status, and malnutrition.A 1/29/26 at 12:22 p.m. nurse's note indicated the resident was visited by a Nurse Practitioner (NP) and found to be lethargic and difficult to rouse. The NP ordered the resident sent to the emergency room (ER).A 1/29/26 6:30 p.m. nurse's note indicated the resident was admitted to the hospital.A 1/29/26 notice of transfer/discharge document, provided by the DON on 4/20/26 at 11:18 a.m., lacked an attached bed hold policy. The clinical record lacked documentation that the resident and/or their representative was provided with a written copy of the transfer/discharge form and/or bed hold policy.During an interview, on 4/20/26 at 11:34 a.m., RN 7 indicated when a resident was sent to the ER, a packet of paperwork including observation and event paperwork, a face sheet (summary of resident's chart), and a notice of transfer/discharge with bed hold policy, were provided to the resident prior to leaving the facility. If the resident was unstable or not cognitively intact, the paperwork was reviewed and signed by the resident representative in person or over the phone. The review of paperwork with the representative was then documented in a progress note.During an interview, on 4/20/26 at 12:50 p.m., the DON indicated when a resident was sent out to the ER, they were sent with a face sheet, continuing care document, and bed hold policy. If the resident was admitted , the paperwork was mailed to the family.A current facility policy, revised 4/18 and titled Emergency Transfer Notifications, provided by the Administrator on 4/20/26 1:54 p.m., included the following: .Policy: When a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon as practicable. Copies of the notices must also be sent to the ombudsman, when practicable.Procedure: 1. Nursing will contact the responsible party/family member to inform them of the pending discharge/transfer to the acute care hospital. Bed hold policy/transfer notification will be reviewed with the responsible party at the time of notification and documented in the medical record.410 IAC (Indiana Administrative Code) 16.2-3.1-12(a)(6)(i-iii)(25)410 IAC 16.2-3.1-12(a)(6)(i-iii)(26)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a required Preadmission Screening and Record Review (PASRR) Level I screening assessment to determine if a Level II assessment was required when the resident received a new major mental illness diagnosis for 1 of 1 resident reviewed for PASRR. (Resident 11)Finding includes:Resident 11's clinical record was reviewed on 4/17/26 at 3:43 p.m. The resident was admitted to the facility on [DATE]. Diagnosis included schizoaffective disorder, bipolar type. This diagnosis was added in July 2024. A 6/6/24, preadmission Level I PASARR Outcome document indicated a Level II assessment was not required. Rationale: There is no evidence of a PASARR condition of an intellectual/developmental disability or a serious behavioral condition. If changes occur or new information refutes these findings, a new screen must be submitted.A current care plan, initiated 7/11/24, indicated the resident had behavioral symptoms of delusions, tangential thoughts, agitation, grandiose thoughts, restlessness, and impulsivity related to schizoaffective disorder. Interventions included continued work with the clinical and psychiatric provider for alternate treatment plans or diagnosis reviews.A 4/13/26, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. The resident was not considered by the state Level II PASRR process to have a serious mental illness and /or intellectual disability or a related condition. Active diagnoses included schizophrenia.During an interview, on 4/20/26 at 11:00 a.m., the Social Services Director (SSD) indicated she was responsible for PASRR screening submissions. Resident 11's last PASRR screening was submitted on 6/6/24 and lacked a major mental diagnosis. She was unable to provide any further PASRR screening submissions since the resident's schizoaffective disorder diagnosis was received on 7/16/24. A PASRR screening should have been submitted when the diagnosis was received. The SSD believed it was overlooked. New diagnoses placed by the in-house providers were reviewed in morning meetings, but she was uncertain of a process to identify when a resident received a new major mental diagnosis from an outside provider.A current facility policy, dated 11/2017, titled PASRR Policy, provided by the Administrator on 4/20/26 at 11:30 a.m., indicated the following: Policy: It is the policy of this facility to ensure that any Pre-admission Screening and Resident Review (PASRR) recommendations which impact those with an Intellectual, Mental Disability or related conditions are completed as prescribed and PASRR assessments are updated with significant changes in mental or physical status.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to ensure communications with a dialysis provider were reviewed to prevent duplicate pneumococcal vaccinations and to ensure continuity of care for 1 or 1 residents reviewed for dialysis. (Resident 2) Findings include:Resident 2's clinical record was reviewed on 4/16/26 at 3:12 p.m. Diagnoses included hypertensive heart disease, chronic kidney disease with heart failure, and acute kidney failure. Current orders included dialysis on Monday, Wednesday, and Friday (1/6/26).A review of the resident's March 2026, Dialysis Communication facility binder indicated Resident 2 received the Pneumococcal 20-valent conjugate vaccine (Prevnar 20) in her left deltoid while at dialysis on 3/2/26.Review of the resident's clinical record vaccination history indicated a Prevnar 20 vaccination was provided, at the facility, on 3/26/26, in the resident's left deltoid.The clinical record lacked historical data of any previous immunizations.A 3/26/26, quarterly, Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired.During an interview, on 4/20/26 at 9:19 a.m., the DON indicated the staff member responsible for reviewing the dialysis communication binder was the Unit Manager (UM) or Infection Preventionist (IP), but there was a time when the facility was without a staff member in either of those positions. The vaccination given at the dialysis appointment should have been documented in the resident's clinical record at the facility.On 4/20/26 at 10:31 a.m., the Corporate Nurse Consultant indicated there was no UM or IP to review the dialysis communication binder at the time the resident would have gotten the Prevnar 20 vaccination at the dialysis appointment. The clinical staff should have been reviewing the communication binder, and the Prevnar 20 vaccination given on 3/2/26 should have been documented in the resident's clinical record.On 4/20/26 at 11:10 a.m., RN 4 indicated when a resident returned from dialysis, the communication binder should be reviewed by the nurse assigned to the hall. Important information from the communication binder should be documented in the resident's clinical record at the facility.On 4/20/26 at 11:12 a.m., the IP (Float) indicated the resident's clinical record should be reviewed prior to giving any vaccination. The facility followed the CDC guidelines for all vaccinations.A current facility policy, reviewed 11/17, titled, Dialysis Care, provided by the Administrator on 4/14/26 at 3:17 p.m., indicated the following: . 5. The nurse in charge at time of return will review paperwork for new orders and/or notes accompanying the resident. 6. The facility will employ a method of communication between the facility and the dialysis center to relay changes in condition and response to treatment . 410 IAC (Indiana Administrative Code) 16.2- 3.1-37(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure pharmacy recommendations were completed in a timely manner and per facility policy for 3 of 5 residents reviewed for unnecessary medications. Findings include: 1.Resident 3's clinical record was reviewed on 4/16/26 at 1:01 p.m. Diagnosis included chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, and morbid obesity due to excess calories. Discontinued orders (on 3/11/26) included ipratropium-albuterol (to treat airflow) solution 0.5 milligrams (mg)-3 mg/3 milliliters (mL); use one vial by inhalation, every 6 hours as needed for shortness of breath; ondansetron (to treat nausea) disintegrating tablet 8 mg, give one tablet every 8 hours as needed for nausea and vomiting; polyethylene glycol 3350 powder (laxative) give 17 grams (gm) oral, mixed with 8 ounces (oz) of fluid, once daily as needed for constipation. A 1/7/26, pharmacy review indicated to see the report for irregularities. A 1/7/26, pharmacy recommendation indicated to consider discontinuation of the as needed orders of ipratropium-albuterol solution, ondansetron, and polyethylene glycol 3350 powder for the due to a lack of use within the previous 60 days. The provider signed the recommendation on 3/10/26 and indicated to discontinue the as needed orders. 2.Resident 5's clinical record was reviewed on 4/17/26 at 11:02 a.m. Diagnosis included COPD, coronary artery disease, and peripheral vascular disease. Discontinued orders included cetirizine (an antihistamine) 10 mg once daily. The order was discontinued on 4/14/26. A 1/7/26, pharmacy review indicated to see the report for irregularities. A 1/7/26, pharmacy recommendation indicated to discontinue cetirizine as administration should be limited to the allergy season in order to avoid adverse events attributed to daily long-term use. The provider signed the recommendation on 3/10/26 and indicated to discontinue the cetirizine with an end date of 4/14/26. 3. Resident 6's clinical record was reviewed on 4/15/26 at 3:50 p.m. Diagnoses included chronic atrial fibrillation, hypertensive heart disease with heart failure, and hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side. Current orders included amiodarone (heart rhythm medication) 100 mg once daily and TSH (thyroid stimulating hormone) once (3/12/26). The clinical record lacked future orders for TSH every 6 months. Discontinued orders included cyclobenzaprine (muscle relaxer) 10 mg as needed at bedtime for muscle spasms. The order was discontinued on 3/11/26. A 12/22/25, quarterly, Minimum Data Set assessment indicated the resident was moderately cognitively impaired. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current care plan, dated 3/10/23, indicated Resident 6 was at risk for ineffective tissue perfusion related to atrial fibrillation, heart failure, and hemiplegia and hemiparesis related to a cerebrovascular accident (stroke). Interventions included labs as ordered (3/10/23). A 1/7/26 pharmacy review indicated to see the report for irregularities. A 1/7/26 pharmacy recommendation indicated to consider discontinuation of cyclobenzaprine due to a lack of use within the previous 60 days. The provider signed the recommendation on 3/10/26 and indicated to discontinue cyclobenzaprine. A 1/7/26 pharmacy recommendation indicated the resident received amiodarone but lacked a TSH lab in the medical record within the past six months. Amiodarone may cause hypothyroidism or hyperthyroidism due to its substantial iodine content. Please monitor TSH on the next convenient lab day and every six months thereafter. The provider signed the recommendation on 3/10/26 and ordered a TSH for 3/12/26. During an interview on 4/20/26 at 1:07 p.m., the DON indicated she was new to the pharmacy review process. She received the recommendations via email, printed the recommendations, and physically handed them to the provider immediately. The NP was at the facility on Tuesdays and Thursdays. The physician got them if he was available. Pharmacy recommendations were returned to her from the providers in varied time frames but as soon as possible. She tried to get the process completed within 30 days. The Pharmacist and DON restarted the process If there were missing recommendations during the monthly review. On 4/20/26 at 1:07 p.m., the Corporate Nurse Consultant indicated the facility aimed for 30 days or by the next review per regulation. The recommendations were reviewed in manager meetings. Some prioritization took place based on medication types and the residents' clinical conditions. Gradual drug reductions were a priority. Sometimes the urgency was less, and those recommendations might take longer to be completed. A current facility policy, last revised 10/2018, titled Medication Regimen Reviews and Pharmacy Recommendations, provided by the Administrator on 4/17/26 at 2:06 p.m., indicated the following: I. Purpose: It is the policy. that the facility maintains the resident's highest practicable level of physical, mental, and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible by providing oversight by a licensed Pharmacist, Attending Physician, Medical Director, and Director of Nursing. II. Policy Medication Regimen Review. The Pharmacist will review each resident's medication regimen at least once a month. The Consultant Pharmacist recommendations will be reviewed by the Director of Nursing and the Attending Physician will be notified promptly of any recommendations needing immediate attention. Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving. Once reviewed by the Physician the pharmacy recommendations will be filed in the resident's medical record. 410 IAC (Indiana Administrative Code) 16.2-3.1-25(i)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to ensure pneumococcal vaccinations were provided following the Centers for Disease Control and Prevention (CDC) guidelines and facility policy to prevent duplication of administration for 1 of 6 residents reviewed for immunizations. (Resident 2) Findings include:Resident 2's clinical record was reviewed on 4/16/26 at 3:12 p.m. Diagnoses included hypertensive heart disease, chronic kidney disease with heart failure, and acute kidney failure. A review of the resident's March 2026, Dialysis Communication facility binder indicated Resident 2 received the Pneumococcal 20-valent conjugate vaccine (Prevnar 20) in her left deltoid while at dialysis on 3/2/26.Review of the resident's clinical record vaccination history indicated a Prevnar 20 vaccination was provided, at the facility, on 3/26/26, in the resident's left deltoid.The clinical record lacked historical data of any previous immunizations.A 3/26/26, quarterly, Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired.During an interview, on 4/20/26 at 9:19 a.m., the DON indicated the staff member responsible for reviewing the dialysis communication binder was the Unit Manager (UM) or Infection Preventionist (IP), but there was a time when the facility was without a staff member in either of those positions. The vaccination given at the dialysis appointment should have been documented in the resident's clinical record at the facility.On 4/20/26 at 10:31 a.m., the Corporate Nurse Consultant indicated there was no UM or IP to review the dialysis communication binder at the time the resident would have gotten the Prevnar 20 vaccination at the dialysis appointment. The clinical staff should have been reviewing the communication binder, and the Prevnar 20 vaccination given on 3/2/26 should have been documented in the resident's clinical record.On 4/20/26 at 11:10 a.m., RN 4 indicated when a resident returned from dialysis, the communication binder should be reviewed by the nurse assigned to the hall. Important information from the communication binder should be documented in the resident's clinical record at the facility.On 4/20/26 at 11:12 a.m., the IP (Float) indicated the resident's clinical record should be reviewed prior to giving any vaccination. The facility followed the CDC guidelines for all vaccinations.A current facility policy, reviewed 11/17, titled, Dialysis Care, provided by the Administrator on 4/14/26 at 3:17 p.m., indicated the following: . 5. The nurse in charge at time of return will review paperwork for new orders and/or notes accompanying the resident. 6. The facility will employ a method of communication between the facility and the dialysis center to relay changes in condition and response to treatment.A current facility policy, reviewed 12/24, titled, Pneumococcal Vaccination, provided by the Administrator on 4/20/25 at 11:24 a.m., indicated the following: . To reduce morbidity and mortality from pneumococcal disease by vaccination all residents who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. The are three pneumococcal conjugate vaccines (PCV15, PCV 20, PCV21). The different vaccines are recommended for different people based on their age and medical status. If PCV 20 or PCV 21 is used, a dose of PPSV 23 isn't indicated. Regardless of which vaccine is used (PCV 20 or PCV 21), their pneumococcal vaccinations are complete. 8. Pneumonia vaccine administration procedure: .f. Document administration in the electronic medical record. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)(5)