STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155796	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedars The	14409 Sunrise CT Leo, IN 46765

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure physician orders were followed for 3 of 12 residents reviewed (Resident 7, Resident 18 and Resident 20).Findings include: Resident 7's record was reviewed on 8/29/25 at 12:29 PM. Diagnoses included atrial fibrillation (irregular heartbeat that leads to blood clots) and anemia. Resident 7's Comprehensive Minimum Data Set (MDS), dated [DATE], indicated their Brief Interview for Mental Status (BIMS) score was 9 (moderate cognitive impairment). A physician order, dated 7/1/25, indicated Resident 7 was to be administered warfarin sodium (warfarin) 4 milligrams (mg) every Monday, Tuesday, Wednesday, Thursday and Friday for prevention of blood clots. A physician order, dated 7/5/25, indicated Resident 7 was to be administered warfarin 5 mg every Saturday and Sunday. The physician order indicated warfarin was not to be administered on Monday 8/11/25 and Tuesday 8/12/25. A lab report, dated 8/11/25, indicated Resident 7's blood clotting time (INR) was critically high at 5.1 (normal target range is 2-3.5). A review of progress notes, dated 8/11/25 through 8/18/25 did not indicate the physician had been notified of the lab. Resident 7's Medication Administration Record, (MAR), dated 8/1/25 through 8/31/25, indicated the resident had been administered warfarin 5 mg on Monday 8/12/25. A lab report, dated 8/18/25, indicated Resident 7's INR was 4.6. A progress note, dated 8/19/25 at 2:31 PM, indicated the Nurse Practitioner (NP) had ordered Resident 7 to be administered vitamin K (helps blood to clot) 2.5 mg STAT (immediately). The NP ordered warfarin to be held for the next 2 days and INR to be tested on the next lab day. In an interview, on 9/2/2025 at 10:04 AM, the Administrator indicated they had not been aware of Resident 7 receiving warfarin after a physician ordered warfarin to be on hold. A current facility policy, titled Medication Administration, dated 1/1/25, indicated medications would be administered according to physician orders. The policy indicated medications outside of physician parameters should be held. The policy indicated the MAR should be reviewed to identify medications (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be administered. 2. Resident 18's record was reviewed on 08/29/25 at 9:17 AM. Diagnoses included hypertension, kidney and ureter disorder, and dementia. A review of Resident 18's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 12 (moderate cognitive impairment). A review of Resident 18's current care plan indicated there were no care plans for daily weights. A review of physician orders, dated 05/29/25 at 06:00 AM, indicated Resident 18 would be weighed daily each morning to monitor for increased edema and weight gain. A review of progress notes, dated 5/30.25 through 9/2/25 indicated there were no documented refusals for Resident 18 missing 26 daily weights between the dates of 05/30/25 and 08/22/25. In an interview, on 08/29/25 at 10:30 AM, Employee 9 indicated Resident 18 had daily weights ordered for fluid shifting and edema in lower extremities. Resident 18 refused weights, routine care, and diet orders often. When refusals occurred, the refusals should be charted in progress notes, and the resident would be reapproached by the DON (Director of Nursing). In an interview, on 08/29/25 at 10:45 AM, the DON indicated she was unsure of why Resident 18 was started on daily weights and has not been told of refusals were occurring. She was not aware Resident 18 had missed 26 weights. When a resident refused, the DON's expectation was to be informed so she could attempt to reapproach them. Employee 9 indicated refusal of care should be documented in the progress notes. In an interview, on 08/29/25 at 11:15 AM, the Administrator indicated she was not aware of Resident 18's refusal of weights. Employees were expected to report refusals to the DON so another attempt could be made, and refusals were to be documents in progress notes. A current policy, dated 01/01/25, provided by the DON, indicated residents who were clinically indicated would have their weight monitored daily. 3. Resident 20's record was reviewed on 08/27/2025 at 11:27 AM. Diagnoses included primary hypertension and hyperlipidemia. A review of Resident 20's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). A review of physician orders, dated 5/15/2025 at 2:12 PM ,indicated Metoprolol Succinate ER 25 MG was to be given one time a day related to hypertension. The order indicated to not give Metoprolol for systolic blood pressure less than 110 and/or diastolic blood pressure less than 60 or pulse less than 60. A review of physician orders, dated 5/15/2025 at 2:12 PM, indicated Isosorbide Mononitrate 60 mg was to be given one time a day related to hypertension. the order indicated to not give Isosorbide for systolic blood pressure less than 110 and/or diastolic blood pressure less than 60 or pulse less than 60. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of physician orders, dated 5/15/2025 at 2:12 PM, indicated Losartan Potassium 25 mg was to be given one time a day related to hypertension. The order indicated to not give Losartan for systolic blood pressure less than 110 and/or diastolic blood pressure less than 60 or pulse less than 60. A review of the August 2025 Medication Administration Record (MAR) indicated missing blood pressure and heart rate measurements for [DATE], 3, 8, 9,10, and 15th for 3 of 3 medications with an order to hold if blood pressure is less than 110 and/or diastolic blood pressure less than 60 hold medication or pulse less than 60. One resident refusal was documented on August 7, 2025, at 8:00 AM. A review of Vital Signs measurements dated August 2025 indicated missing blood pressure and heart rate measurements for the mornings of August 1, 2, 3, 8, 9,10, and 15th, 2025 between 7:00 AM and 9:00 AM. In an interview, on 8/28/2025 at 9:17 AM, LPN 4 indicated blood pressure and heart rate should be measured before giving Metoprolol to make sure measurements were not below the hold parameters. A current policy dated 1/1/25, provided by the Administrator indicated blood pressure and heart rate measurements were required when giving antihypertensives (Metoprolol, Isosorbide Mononitrate, Losartan). When applicable, hold medication for blood pressure and/or heart rate outside the physician's prescribed parameters. Sign MAR after administration and record vital signs onto the MAR and document any refusals. 3.1-37

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident specific accident prevention interventions were implemented for 2 of 12 residents reviewed (Resident 7 and Resident 21).Findings include: Resident 7's record was reviewed on 8/29/25 at 12:29 PM. Diagnoses included dementia and right upper arm fracture. Resident 7's Comprehensive Minimum Data Set, (MDS), dated [DATE], indicated their Brief Interview for Mental Status (BIMS) score was 9 (moderate cognitive impairment). The MDS indicated Resident 7 had no impairment of their arms or legs. The MDS indicated Resident 7 required staff supervision or touching assistance with walking. The MDS indicated Resident 7 had experienced 2 falls. A clinical assessment log indicated Resident 7 had experienced falls on the following dates: 1/18, 1/20, 1/21, 3/28, 7/30, 7/31, 8/6, 8/9, 8/12, 8/15, 8/17, 8/20, 8/22, and 8/26/25. Resident 7's care plan, dated 2/6/25, indicated they had a behavior of not waiting for staff assistance. The target goal was to have fewer episodes by 10/24/25. Interventions included anticipating, meeting the residents' needs and medications as ordered. Resident 7's care plan, dated 2/3/25, indicated they had a risk for falls due to confusion, deconditioning, poor balance and unawareness of safety needs. The target goal was for Resident 7 to be free from falls through 10/24/25. Fall interventions initiated on 1/24/25 included a touch pad call light and removal of wheelchair foot pedals. Fall interventions initiated on 2/3/25 included call light in reach, physical activities, and appropriate footwear. Therapy evaluation was initiated as a fall prevention intervention on the following dates 1/24, 2/3, 4/1, 7/31, and 8/22/25. Resident 7's care plan for fall prevention did not include any alternative fall prevention interventions or therapy recommendations for fall prevention on the following dates 8/6, 8/9, 8/12, 8/15, and 8/17/25. Resident 7's care plan for fall prevention did not include any alternative fall prevention interventions or therapy recommendations for fall prevention until 8/20/22. In an interview, on 9/2/2025 at 10:04 AM, the Administrator indicated each fall should have been reviewed. The Administrator indicated alternative interventions should have been considered after each fall. The Administrator indicated any new therapy recommendations should have been implemented after each therapy evaluation. 2. During an observation, on 8/29/2025 at 1:48 PM, Resident 21's room had anti-slip tape strips on the floor at the bedside and in front of the recliner. Anti slip tape was not in the resident's bathroom. Resident 21's record was reviewed on 08/26/2025 at 11:00 AM. Diagnoses included moderate dementia, Parkinson's Disease, and muscle weakness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 21's current quarterly MDS, dated [DATE], indicated their BIMS (Basic Interview for Mental Status) score was 5 (cognitively impaired). A review of an initial fall assessment, dated 8/20/25 at 7:30 AM indicated, Resident 21 was found lying on the bathroom floor. 3 skin tears were observed to the resident's left elbow area. Poor balance was indicated as normal for Resident 21. A list of all interventions in place at the time of fall was for 3rd shift staff to toilet resident between 5-530am per wife request. Documentation failed to include if Resident 21's call light was in reach or if a motion detector was in use in at the time of the fall. A review of Toilet Use tasks documented on 8/20/25 indicated staff had documented assisting Resident 21 to the toilet at 1:50 AM, and next at 8:21 PM. A review of tasks documented on 8/20/25 indicated staff had documented toileting for Resident 21 at 4:30 AM. AM Toileting was not documented between 5:00 AM- 8:00 AM on 8/24/25, 8/25/25, 8/26/25, 8/27/25, 8/28/25, 8/29/25, 8/30/25, 9/1/25, 9/2/25. In an interview, on 8/29/2025 at 2:02 PM, CNA 6 indicated resident refusals were charted in tasks. Some residents had a paper log posted on a wall to indicate when toileting occurred. Resident 21 didn't have a paper log in his room. In an interview, on 8/29/2025 at 2:53 PM, the Director of Nursing indicated AM Care would be between 5:00-8:00 AM. Anti-slip tape in the bathroom would be a potential intervention that was not in place. A review of Resident 21's current Care plan, titled At Risk for Falls, indicated the resident had problems of confusion, deconditioning, gait and balance problems, and incontinence. Interventions included staff to offer routine toileting prior to AM care and anticipate and meet the resident's needs, assure the resident's call light was within reach. Resident 21 needed prompt response to all requests for assistance. A motion sensor was placed in Resident 21's room, assure nonskid strips were in front of the bed and recliner to allow for better footing when attempting to ambulate. Staff was to remind Resident 21 to wait for assistance if he was feeling weak. In an interview, on 09/02/2025 at 9:56 AM, the DON indicated Resident 21 was no longer supposed to be routinely toileted before 6:00 AM. Staff was aware of the 5AM Toileting schedule. A current policy, undated, provided by the Administrator on 9/2/25 at 11:00 AM, indicated each resident will receive care and services in accordance with their individualized risk for falls. Fall risk interventions included the call light being within reach, implementing a routine rounding schedule, unsure adequate lighting in the resident environment, increase the frequency of rounding by staff, and scheduling ambulation or toileting assistance. The Care Plan will be revised as needed. 3.1-45(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were disposed when expired and labeled when opened for 3 of 6 residents reviewed. (Resident 35, Resident 24, and Resident 39) On [DATE] at 9:40 AM, Registered Nurse (RN) 5 was observed preparing medications for Resident 35. An opened vial of Resident 35's insulin was observed to have a handwritten open date of [DATE]. RN 5 indicated the inulin should have been disposed of 30 days after the open date.On [DATE] at 9:47 AM, RN 5 was observed examining open medications in the medication cart. RN 5 indicated Resident 24's eye lubricant had been opened and had not been labeled with an open date. RN 5 indicated Resident 39's inhaler had been opened and had not been labeled with an open date. RN 5 indicated all medications should be labeled with the date the medication had been opened.Resident 35's record was reviewed on [DATE] at 10:55 AM. Resident 35 had been diagnosed with diabetes.A physician order indicated Resident 35 was to be administered insulin on a sliding scale 4 times a day.2. Resident 24's record was reviewed on [DATE] at 11:30 AM. Resident 24 had been diagnosed with dry eye syndrome.Resident 24's eye lubricant label indicated the medication could be administered 1 or 2 drops to the affected eye as needed.3. Resident 39's record was reviewed on [DATE] at 11:24 AM. Resident 35 had been diagnosed with a cough.A physician order, dated [DATE], indicated Resident 39 could be administered 2 puffs of albuterol inhalant every 6 hours as needed for wheezing, cough or shortness of breath.A current facility policy, titled Medication Administration, dated [DATE], indicated medication expirations dates should be identified and the nurse manager should be notified.A current facility policy, titled Medication Storage, dated [DATE], indicated medication storage areas should be inspected routinely for outdated and discontinued medications.3.1-25(j)(m) and (n)