STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELLENIC SENIOR LIVING OF MISHAWAKA	1540 SOUTH LOGAN STREET, MISHAWAKA, , 46544

(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 the Investigation of Complaints IN00368373 and IN00369128. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00368373 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00369128 - Substantiated. State residential findings related to the allegations are cited at R0144, R0155, R0240, R0297 and R0407. Survey dates: December 15, 16, 17, and 20, 2021 Facility number: 014224 Residential Census: 122 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on	R 0000	The Plan of Correction is neither an agreement with nor an admission of wrong doing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of January 21, 2022.	

	12/28/21.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (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. Based on observation and interview, the facility failed to ensure a clean and sanitary environment for 1 of 4 public restrooms. (Floor 3) Finding includes: On 12/16/2021 at 12:25 P.M., during a random observation of a resident/public restroom on the 3rd floor, the following was observed: a dried brown substance (feces) on 6 to 7 floor tiles with a dried red colored liquid on the front edge of the toilet bowl. During an interview on 12/16/2021 at 12:27 P.M., the Regional Director of Clinical Services (RDCS) indicated "this is unacceptable". She indicated the facility had been without environmental services for 2 to 3 months, and the aides were the ones who should be doing the cleaning and "they are working their butts off already." The RDCS indicated they have	R 0144	Despite all residents having the potential to be negatively impacted by the soiled toilet, no residents were identified as having a infection that might have been caused by a soiled toilet based on a review of100% of the infections since November 1, 2021. Therefore, no residents were identified or requiredinterventions for negative outcomes from the soiled toilet. The bathroom was cleaned and thoroughlydisinfected following the occurrence. Staff has been unable to identify the person responsible for the occurrence to provide education butwere able to determine that this was due to a staff member or visitor due to the type of soiling that wasfound. Therefore, 100% of staff members were provided education on cleaning and disinfecting a toilet in the event they soil the toilet or bathroom stall or if they find the toilet or bathroom stall in an uncleanstate were trained on the practice as of January 24, 2022, or prior to the next shift worked thereafter.	01/24/2022

	hired the housekeeping services out now and they have been working on the resident rooms. On 12/17/2021 at 2:00 P.M., the Administrator provided the policy titled,"Environmental Services", undated, and indicated the policy was the one currently used by the facility. The policy indicated"... Unit Cleaning: [Name of facility] maintains all common areas ...." This state residential finding relates to Complaint IN00369128. Based on observation and interview, the facility failed to ensure a clean and sanitary environment for 1 of 4 public restrooms. (Floor 3) Finding includes: On 12/16/2021 at 12:25 P.M., during a random observation of a resident/public restroom on the 3rd floor, the following was observed: a dried brown substance (feces) on 6 to 7 floor tiles with a dried red colored liquid on the front edge of the toilet bowl. During an interview on 12/16/2021 at 12:27 P.M., the Regional Director of Clinical Services (RDCS) indicated "this is unacceptable". She indicated the facility had been without environmental services for 2 to 3 months, and the aides were		Assigned team members will perform audits of the common area bathrooms per shift for 7 days per week for one month and once daily for two months thereafter to ensure ongoing compliance with the cleanliness and sanitation of common area bathrooms. (See attached Bathroom Audit. The community will be compliant as of January 24, 2022.	

	the ones who should be doing the cleaning and "they are working their butts off already." The RDCS indicated they have hired the housekeeping services out now and they have been working on the resident rooms. On 12/17/2021 at 2:00 P.M., the Administrator provided the policy titled,"Environmental Services", undated, and indicated the policy was the one currently used by the facility. The policy indicated"... Unit Cleaning: [Name of facility] maintains all common areas ...." This state residential finding relates to Complaint IN00369128.			
R 0155	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(l) (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items.	R 0155	Despite all residents having the potential to be negatively impacted by the trash found in a common area, no residents were identified as having an infection that might have been caused by exposure based on a review of 100% of the infections since November 1, 2021. Therefore, no residents were identified or required interventions for negative outcomes. The trash was removed from the common area. Upon investigation, it was identified that the trash in the common area was primarily placed there by residents or agency staff members. This is in part due to the difficulty of	01/24/2022

	Based on observation and interview, the facility failed to dispose of garbage timely to prevent overflowing of garbage in barrels and garbage bags on the floor for 1 of 3 floors observed. Finding includes: During an interview, on 12/16/2021 at 10:42 A.M., Resident V indicated the staff are leaving trash from the resident rooms along the hall right next to the dining room and some of those bags have wet briefs in them. On 12/16/2021 at 12:16 P.M., the following was observed in a small hallway adjacent to the main dining room: 3 large trash barrels with trash bags extending out of the barrels, 2 trash bags, and 4-5 broken down cardboard boxes on the floor. During an interview on 12/16/2021 at 12:27 P.M., the Regional Director of Clinical Services (RDCS) indicated the facility had been without environmental services for 2 to 3 months, and the aides were the ones who should be doing the cleaning and "they are working their butts off already." The RDCS indicated they have hired the housekeeping services out now and they have been working on the resident rooms.		reaching the dumpster.Covered trash receptacles have been placed on each floor for residents and staff to reduce waste in the common areas. Trash from those receptacles will be taken by staff to the dumpster daily as scheduled. Once the weather breaks, the community will be adding an additional walkway to encourage access to the dumpster. All residents will be educated on the location of trash receptacles and the system for trash removal. All staff members will be educated on the location of trash receptacles, the process for trash removal and the need to remove any trash found in common areas to a trash receptacle at the time it is found. Trash removal will be monitored on a daily basis for one month and weekly for two months thereafter. (See attached Trash Audit form) The community will be compliant by January 24, 2022.	

	On 12/17/2021 at 11:00 A.M., 3 trash barrels were observed in the hallway adjacent to the main dining room with trash overflowing out of the barrels and boxes on the floor. At that time, an aide was overheard saying "This is terrible, they don't take out their trash. It was all the way over to the other wall last week." On 12/17/2021 at 2:00 P.M., the Administrator provided the policy titled, "Environmental Services", undated, and indicated the policy was the one currently used by the facility. The policy indicated "... Trash Disposal: Housekeeping will remove trash on assigned housekeeping days...." This state residential finding relates to Complaint IN00369128. Based on observation and interview, the facility failed to dispose of garbage timely to prevent overflowing of garbage in barrels and garbage bags on the floor for 1 of 3 floors observed. Finding includes: During an interview, on 12/16/2021 at 10:42 A.M., Resident V indicated the staff are leaving trash from the resident rooms along the hall right next to the dining room and some of those bags have wet			

	briefs in them. On 12/16/2021 at 12:16 P.M., the following was observed in a small hallway adjacent to the main dining room: 3 large trash barrels with trash bags extending out of the barrels, 2 trash bags, and 4-5 broken down cardboard boxes on the floor. During an interview on 12/16/2021 at 12:27 P.M., the Regional Director of Clinical Services (RDCS) indicated the facility had been without environmental services for 2 to 3 months, and the aides were the ones who should be doing the cleaning and "they are working their butts off already." The RDCS indicated they have hired the housekeeping services out now and they have been working on the resident rooms. On 12/17/2021 at 11:00 A.M., 3 trash barrels were observed in the hallway adjacent to the main dining room with trash overflowing out of the barrels and boxes on the floor. At that time, an aide was overheard saying "This is terrible, they don't take out their trash. It was all the way over to the other wall last week." On 12/17/2021 at 2:00 P.M., the Administrator provided the policy titled, "Environmental Services", undated, and			

	indicated the policy was the one currently used by the facility. The policy indicated "... Trash Disposal: Housekeeping will remove trash on assigned housekeeping days...." This state residential finding relates to Complaint IN00369128.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review, observation and interview, the facility failed to provide personal care and assistance with medication administration related to not following standards of practice when administering medications by visually observing residents take medications that were provided for 3 of 10 residents reviewed for medications administered. (Residents D, K, and Q) Findings include: 1. During an interview on 12/15/2021 at 1:50 P.M., the family of Resident D indicated she wanted to voice a concern. The family member indicated she had gone up to her mother's	R 0240	A review of the resident's medical record was completed for each resident identified in the survey. Thereview did not find any adverse consequences that could be tied to the medication administration not being observed. While the community was unable to identify all residents whose medication was left in their apartment,it is assumed that 100% of resident have the potential to have been negatively impacted by this allegedpractice. A review of all transfers to hospital, deaths, change in conditions and incident reports did notreveal any negative consequences that might have been associated with medication administration notbeing observed. All nurses and qualified medication aides on staff will be provided education on proper medication administration. All agency staff who administer medication will be provided written statement regarding the expectation to observe all medication administrations while they serve	01/24/2022

	room and found her morning pills in the cup still not taken. She indicated the staff bring them to her and don't watch her actually take them. A clinical record review was completed on 12/15/2021 at 1:55 P.M. Resident D's diagnoses included, but were not limited to: diabetes, polyneuropathy, depression and chronic kidney disease. Resident D's current Physician Orders indicated she was to receive the following medications in the morning every day: Calcium, Citalopram (for depression), Glipizide (anti diabetic), Januvia (anti diabetic), one a day vitamin, Maxide (diuretic), vitamins C & D3, Lamotrigine (anticonvulsant), Metoprolol (hypertension drug), and Quetiapine (antipsychotic). 2. During an interview on 12/17/2021 at 9:50 A.M., Resident K indicated she takes her medications after she eats. At that time, there was a paper medication cup with numerous pills of different colors and shapes observed on a night stand table. No nursing staff were in the room. Resident K's current Physician Orders indicated the resident was to receive the following medications in the morning:		this community atthe start of their shift. An assigned team member will evaluate all existing team members for medication administration practices. In addition, an assigned team member will audit 5% of rooms of residents for whom the community provides medication administration weekly for 3 months. (See attached Medication Administration audit form) The community will be compliant by January 24, 2022.	

	aspirin, Calcitriol (vitamin), Famotidine (antihistamine), Ferosol (iron replacement), Fexofenadine (anti histamine), Furosemide (diuretic), Lisinopril (high blood pressure), Pantoprazole (antacid), Potassium Chloride (potassium salt), Pravastatin (high cholesterol), Venlafaxine (antidepressant) 3. During a medication administration observation on 12/16/2021 at 7:26 A.M., QMA 4 was observed to go into Resident Q's room to administer medications. QMA 4 announced herself to the resident and communicated to Resident Q she had left her medications on the night stand. Resident Q's current Physician Orders, dated 12/2021, indicated she was to receive: Linzess (stomach medication), aspirin, Atorvastatin (cholesterol), Duloxetine (antidepressant), Esompra (stomach med), Loratadine (antihistamine), Metoprolol (heart medication), Montelukast (anti inflammatory), nitroglycerine, vitamin D3, Acetaminophen (analgesic), Mag Oxide (mineral), Meclizine (antihistamine), Pregabalin (pain medication) and Clopidogrel blood thinner). During an interview on 12/16/2021 at 7:30 A.M., QMA 4			

indicated she should not have left medications in the residents' rooms.

On 12/17/2021 at 1:50 P.M., the Director of Nursing provided the policy titled," Staff Administered Medications", dated March 1, 2021, and indicated the policy was the one currently used by the facility. The policy indicated 5. Offer the resident the ordered medications as indicated by he Medication Sheets. Use a paper medicine cup, not your hands. Hand the medication to the resident and observe him or her swallow it. Never leave a medication unattended when it is outside of the medication cupboard...."

This state residential finding relates to Complaint IN00369128.

Based on record review, observation and interview, the facility failed to provide personal care and assistance with medication administration related to not following standards of practice when administering medications by visually observing residents take medications that were provided for 3 of 10 residents reviewed for medications administered. (Residents D, K, and Q)

Findings include:

1. During an interview on 12/15/2021 at 1:50 P.M., the

family of Resident D indicated she wanted to voice a concern. The family member indicated she had gone up to her mother's room and found her morning pills in the cup still not taken. She indicated the staff bring them to her and don't watch her actually take them.

A clinical record review was completed on 12/15/2021 at 1:55 P.M. Resident D's diagnoses included, but were not limited to: diabetes, polyneuropathy, depression and chronic kidney disease.

Resident D's current Physician Orders indicated she was to receive the following medications in the morning every day: Calcium, Citalopram (for depression), Glipizide (anti diabetic), Januvia (anti diabetic), one a day vitamin, Maxide (diuretic), vitamins C & D3, Lamotrigine (anticonvulsant), Metoprolol (hypertension drug), and Quetiapine

(antipsychotic).

2. During an interview on 12/17/2021 at 9:50 A.M., Resident K indicated she takes her medications after she eats. At that time, there was a paper medication cup with numerous pills of different colors and shapes observed on a night stand table. No nursing staff were in the room.

	Resident K's current Physician Orders indicated the resident was to receive the following medications in the morning: aspirin, Calcitriol (vitamin), Famotidine (antihistamine), Ferosol (iron replacement), Fexofenadine (anti histamine), Furosemide (diuretic), Lisinopril (high blood pressure), Pantoprazole (antacid), Potassium Chloride (potassium salt), Pravastatin (high cholesterol), Venlafaxine (antidepressant) 3. During a medication administration observation on 12/16/2021 at 7:26 A.M., QMA 4 was observed to go into Resident Q's room to administer medications. QMA 4 announced herself to the resident and communicated to Resident Q she had left her medications on the night stand. Resident Q's current Physician Orders, dated 12/2021, indicated she was to receive: Linzess (stomach medication), aspirin, Atorvastatin (cholesterol), Duloxetine (antidepressant), Esompra (stomach med), Loratadine (antihistamine), Metoprolol (heart medication), Montelukast (anti inflammatory), nitroglycerine, vitamin D3, Acetaminophen (analgesic), Mag Oxide (mineral), Meclizine (antihistamine), Pregabalin (pain medication) and Clopidogrel			

	blood thinner). During an interview on 12/16/2021 at 7:30 A.M., QMA 4 indicated she should not have left medications in the residents' rooms. On 12/17/2021 at 1:50 P.M., the Director of Nursing provided the policy titled," Staff Administered Medications", dated March 1, 2021, and indicated the policy was the one currently used by the facility. The policy indicated 5. Offer the resident the ordered medications as indicated by he Medication Sheets. Use a paper medicine cup, not your hands. Hand the medication to the resident and observe him or her swallow it. Never leave a medication unattended when it is outside of the medication cupboard...." This state residential finding relates to Complaint IN00369128.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with	R 0297	A review of the resident’s medical record was completed for each resident identified in the survey. Thereview did not find any adverse consequences that could be tied to the medication administration not being provided. While the community was unable to identify all residents whose medication was not available, it is assumed that 100% of resident for	01/24/2022

	prescribed medications in accordance with applicable laws of Indiana. Based on record review and interview, the facility failed to ensure medications were available for administration for 11 of 16 residents reviewed for medications. (Residents B, H, J, K, M, P, Q, W, BB, CC, and DD) Findings include: 1. During an interview, on 12/15/2021 at 11:30 A.M., Resident B indicated she had not received some of her medications lately. A clinical record review was completed on 12/15/2021 at 12:16 P.M. Resident B's diagnoses included, but were not limited to vitamin D deficiency, obesity, depression hypertension. Current Physician's Orders, dated 12/1/2021, indicated Resident B was to receive Vitamin D3 2000 units 1 capsule daily. The Medication Administration Record dated 12/1/2021 through 12/31/2021 indicated the Vitamin D3 was not initialed as given from 12/1 through 12/16/2021. The back of the medication sheet indicated on 12/1/2021 and 12/2/2021 the Vitamin D3 was not available.		whom the community administers medications have the potential to have been negatively impacted by this alleged practice. A review of all transfers to hospital, deaths, change in conditions and incident reports did not reveal any negative consequences that might have been associated with medication not being provided. The community went to each resident’s apartment for whom we administer medication to ensure thatall medication secured in the residents’ apartments for the prior administration method had been transferred to the nursing cart to allow for administration. Secondly, all medication orders were reconciled between the pharmacy, the medication administration record, and the physician orders. Allnurses and qualified medication aides were provided education by the pharmacy regarding proper intake of medications, proper ordering of medication and proper notification in the event of a missingmedication. All nurses and qualified medication aides were also provided education as to the properdocumentation of refusal of medication, lack of administration due to missing medication and medication errors. The team member receiving the medication from pharmacy on a weekly basis will sign off verifying thatall medications ordered were delivered going forward. An assigned team member will audit thoseverifications with each delivery. In the event a medication	

	There was no further documentation as to why the medication was not signed out as been administered. 2. During an interview, on 12/17/2021 at 9:45 A.M., Resident H indicated she had not received Tylenol for 2-3 weeks, was told she had to wait until the medications were refilled and had medications in a locked cabinet in her room that she was not allowed to use. A clinical record review was completed on 12/17/2021 at 9:58 A.M. Resident H's diagnoses included but were not limited to: diabetes, chronic pain and hypertension. Current Physician Orders, dated 12/2/2021, indicated Resident H was to receive Acetaminophen (Tylenol) 500 mg (milligrams) take 2 tablets twice a day routinely, and another order for Acetaminophen 325 mg take 2 tablets every 6 hours as needed for pain or general discomfort. The Medication Administration Record for December 2021 indicated Resident H did not receive the Acetaminophen 500 mg on 12/11 and 12/12/21. The back page of the sheet indicated on 12/10/2021 and 12/14/2021 the Acetaminophen tab 500 mg were not available. 3. During an interview on 12/17/2021 at 10:05 A.M.,		is not available, pharmacy will also notify theRegional Director of Clinical Service and Executive Director with each occurrence to allow these personsto verify site personnel that this is addressed. In addition, a designated team member will audit 10% ofthe Medication Administration Records daily for 7 days after in-service, 10% of the Medication Administration Records weekly for 28 days thereafter and monthly for 3 additional months. The community will be compliant by January 24, 2022.	

	Resident J indicated he had a hard time reading the dial on the insulin pen due to having macular degeneration. The resident indicated, "you never know if you will get your shot or not, it's very inconsistent around here", and indicated he did not get his shot last Saturday and had missed medications too. Physician Orders, dated November 2021, indicated the resident was to receive Novolin insulin 55 units subcutaneous every morning and Furosemide (diuretic medication) 40 mg (milligrams) 1 tablet twice a day. The Medication Administration Record, dated 11/1/2021, indicated the medication Furosemide was circled (indicating the medication was not administered) on the following dates: 11/1 through 11/5, 11/7 through 11/12, 11/16-11/17, and 11/21 through 11/30/2021. The back page of the medication sheet indicated the medication Furosemide was not available on 11/15 x 2 doses, 11/21, 11/22, and 11/23/2021. The sheet lacked further documentation of why the medication was not administered on the other days. 4. During an interview on 12/17/2021 at 9:50 A.M., Resident K indicated she previously had 3 nitro			

	(nitroglycerine) patches on at the same time, but it only happened once. She did not receive her Tylenol all the time and indicated it was not given for 3-4 days. Resident K's Physician Orders, dated November 2021, indicated she was to receive Vitamin C 500 mg daily, Lorazepam (anti-anxiety medication) 0.5 mg 1 tablet at bedtime, Acetaminophen 500 mg 2 tablets every 6 hours as needed for pain or discomfort. The November Medication Administration Record indicated on 11/2, 11/3, 11/4, 11/13, 11/14 and on 11/15 the vitamin C was not available. On 11/20 the Lorazepam was not available. Physician Orders, dated December 2021, indicated Resident K was to receive Famotidine (antacid) 20 mg at bed time, Donepezil (cognition enhancing medication) 10 mg 1 tablet twice a day, Oxybutynin (bladder relaxant) 5 mg 1 tablet twice a day, Sertraline (antidepressant) 100 mg 1 tablet twice a day and Acetaminophen 500 mg 2 tablets every 6 hours as needed for pain or discomfort. The Medication Administration Record indicated on 12/3/2021, the Famotidine was not			

	administered (not given - out of medication); on 12/3/2021 the Donepezil was not administered (not given - out of medication); on 12/2021 the Oxybutynin was not administered (not given - out of medication); on 12/3/2021 the Sertraline was not administered (not given - out of medication): and on 12/3 and 12/14/2021 the Acetaminophen was not administered (not given - out of medication). 5. During an interview on 12/17/2021 at 2:44 P.M., Resident M indicated he received his medications "most of the time." A clinical record review was completed on 12/17/2021 3:02 P.M. Resident M's diagnoses included, but were not limited to: diabetes, diabetic neuropathy and chronic kidney disease. Resident M's current Physician Orders indicated the resident was to receive glimepiride (anti-diabetic medication) 1 mg (milligram) 1 tablet every morning; Pantoprazole 40 mg 1 tablet twice a day; Metoprol 25 mg 1 tablet twice a day, and Metoclopram 5 mg 1 tablet every 6 hours. The Medication Administration Records, dated December 2021, indicated on 12/5 and 12/6/2021 Resident M did not received the glimepiride			

medication due to the medication was not available. On 12/19/2021 the medication Pantoprazole and Metoprol were not administered due to not available. On 12/20/2021 the metoclopram was not administered at 12:00 A.M. due to "resident missed 12 am dose due to missing cart keys".

6. During an interview on 12/17/2021 at 10:30 A.M., Resident P indicated she was going to start doing her own pills. She had missed her gabapentin (nerve pain medication) and was given the wrong pill a couple weeks ago.

A clinical record review was completed on 12/17/2021 at 10:40 A.M. Resident P's diagnoses included, but were not limited to: diabetes, chronic kidney disease, glaucoma and acid reflux.

Resident P's current Physician Orders, dated December 2021, indicated the resident was to receive gabapentin 600 mg 1 tablet twice a day and Tab-a Vite (vitamin) 1 tablet every morning.

The December Medication Administration Record indicated on 12/1, 12/2, 12/6, 1/12, and 12/13/2021 Resident P did not receive the vitamin due to "not available - let resident know she needed it.

	7. During a medication administration observation on 12/16/2021 at 7:26 A.M., QMA 4 was observed to go into Resident Q's room to administer medications. QMA 4 announced herself to the resident and communicated to Resident Q she had left her medications on the night stand. Resident Q's current Physician Orders, indicated the resident was to receive Mag oxide (mineral) 400 mg 1 tablet twice a day and Meclizine (antihistamine) 25 mg 1 tablet twice a day. A Medication Administration Record, dated December 2021, indicated Resident Q did not receive the medications mag oxide and the Meclizine on 12/15/2021 due to the medications were not available. 8. A clinical record review was completed on 12/17/2021 at 2:44 P.M. Resident W's diagnoses included, but were not limited to: diabetes, depression, anxiety and obesity. Resident W's current Physician Orders indicated the resident was to receive Humalog insulin per sliding scale results and another 4 units routinely four times a day. Resident W's Insulin Sheets were reviewed on 12/16/2021 and indicated the resident did			

	not receive insulin injections on the following dates: 2 doses on 12/8/2021 and 1 dose on 12/9/2021 due to resident not in room. 9. A clinical record review was completed on 12/17/2021 at 9:28 A.M. Resident BB's diagnoses included, but were not limited to diabetes, obesity, dementia bipolar and depression. Resident BB's current Physician Orders, indicated the resident was to receive Trulicity insulin 0.5 ml (milliliter) subcutaneous every week on Thursdays. The Insulin Medication Sheet, dated 12/2021, indicated the Trulicity was not administered on 12/2/2021 due to unavailable. 10. A clinical record review was completed on 12/17/2021 on 11:59 A.M. Resident CC's current diagnoses included, but were not limited to: diabetes and hypothyroidism. The current Physician's Orders for Resident CC indicated she was to receive Humalog insulin per sliding scale results.			

The December Medication Administration Record indicated Resident CC did not receive the insulin injections on 12/8 and 12/9 x 2 doses, and on 12/14 x 1 dose.

11. A clinical record review was completed on 12/16/2021 at 1:20 P.M. Resident DD's diagnoses included, but were not limited to: back pain, diabetes, obesity and sleep apnea.

The current physician orders for Resident DD indicated he was to receive Trulicity insulin 0.5 ml subcutaneous every week.

The December Medication Administration Record dated December 2021 indicated the Trulicity insulin was not administered on 12/2/2021 due to the medication was unavailable.

During an interview on 12/16/2021 at 8:51 A.M., QMA 4 indicated if the medications were not in the cart, they were instructed to write on the back of the medication sheet the medication was not available and report it to the nurse. QMA 4 indicated the medications were delivered every Friday night.

During an interview on 12/16/2021 at 10:03 A.M., QMA 3 indicated there was no nurse on 12/8/2021 and the night shift

	nurse stayed over to do the insulin administrations and the evening nurse came in early. During an interview on 12/20/2021 at 10:42 A.M., the Director of Nursing indicated if a resident missed 3 doses of a medication, they were to notify the physician and get it discontinued. If the medications were not in the cart, they should call the back up pharmacy for the medications and/or call the primary pharmacy to see if it had been ordered and when it should be delivered. On 12/17/2021 at 1:50 P.M., the Director of Nursing provided the policy titled, "Medication Availability", dated 3/1/2021, and indicated the policy was the one currently used by the facility. The policy indicated"...In order to most appropriately provide for the care of those residents for whom this community is administering medications, the community must have a supply of that medication ready to administer. 1. Staff members will provide ample notice to residents or power of attorney if medications are needed and the contracted pharmacy is not the preferred pharmacy. 2. If the Resident and/or the Responsible Party have not provided the medication prior to the administration of the final dose and the medication is not			

	available in the community's EDK, the community will order the required medication from the community's contracted pharmacy provider. 3. In the event that the community is administering the last dose of a medication and the medication has not yet arrived from either pharmacy, staff will request a "stat" delivery of the medication from the contracted provider...." On 12/17/2021 at 1:51 P.M., the Director of Nursing provided the policy titled, "Ordering and Receiving Medications From Pharmacy", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...Medications and related products are received from the pharmacy on a timely basis. a). Reorder medication three to four days in advance of need to assure an adequate supply is on hand...." On 12/17/2021 at 1:52 P.M., the Director of Nursing provided the policy titled, "Staff Administration Medication",dated March 1, 2021, and indicated the policy was the one currently used byte the facility. The policy indicated"...2. The Medication Sheets must be reviewed each time the medications are administered to make certain that changes have not been made or medications			

discontinued....8. Draw a circle around the square and initial it when the resident is observed not taking an ordered medication. Indicated on the back of the Medication Sheet the date, time, and reason the medication was not taken. The following are examples of when a resident may not take an ordered medication: A resident refuses too take a medication. Medications are sent with the resident or family members when the resident leaves the community/facility. Doctor orders that a medication temporarily not be given...."

This state residential finding relates to Complaint IN00369128.

Based on record review and interview, the facility failed to ensure medications were available for administration for 11 of 16 residents reviewed for medications. (Residents B, H, J, K, M, P, Q, W, BB, CC, and DD)

Findings include:

1. During an interview, on 12/15/2021 at 11:30 A.M., Resident B indicated she had not received some of her medications lately.

A clinical record review was completed on 12/15/2021 at 12:16 P.M. Resident B's diagnoses included, but were not limited to vitamin D

deficiency, obesity, depression hypertension.

Current Physician's Orders, dated 12/1/2021, indicated Resident B was to receive Vitamin D3 2000 units 1 capsule daily.

The Medication Administration Record dated 12/1/2021 through 12/31/2021 indicated the Vitamin D3 was not initialed as given from 12/1 through 12/16/2021. The back of the medication sheet indicated on 12/1/2021 and 12/2/2021 the Vitamin D3 was not available. There was no further documentation as to why the medication was not signed out as been administered.

2. During an interview, on 12/17/2021 at 9:45 A.M., Resident H indicated she had not received Tylenol for 2-3 weeks, was told she had to wait until the medications were refilled and had medications in a locked cabinet in her room that she was not allowed to use.

A clinical record review was completed on 12/17/2021 at 9:58 A.M. Resident H's diagnoses included but were not limited to: diabetes, chronic pain and hypertension.

Current Physician Orders, dated 12/2/2021, indicated Resident H was to receive Acetaminophen

(Tylenol) 500 mg (milligrams) take 2 tablets twice a day routinely, and another order for Acetaminophen 325 mg take 2 tablets every 6 hours as needed for pain or general discomfort.

The Medication Administration Record for December 2021 indicated Resident H did not receive the Acetaminophen 500 mg on 12/11 and 12/12/21. The back page of the sheet indicated on 12/10/2021 and 12/14/2021 the Acetaminophen tab 500 mg were not available.

3. During an interview on 12/17/2021 at 10:05 A.M., Resident J indicated he had a hard time reading the dial on the insulin pen due to having macular degeneration. The resident indicated, "you never know if you will get your shot or not, it's very inconsistent around here", and indicated he did not get his shot last Saturday and had missed medications too.

Physician Orders, dated November 2021, indicated the resident was to receive Novolin insulin 55 units subcutaneous every morning and Furosemide (diuretic medication) 40 mg (milligrams) 1 tablet twice a day.

The Medication Administration Record, dated 11/1/2021, indicated the medication Furosemide was circled

(indicating the medication was

	not administered) on the following dates: 11/1 through 11/5, 11/7 through 11/12, 11/16-11/17, and 11/21 through 11/30/2021. The back page of the medication sheet indicated the medication Furosemide was not available on 11/15 x 2 doses, 11/21, 11/22, and 11/23/2021. The sheet lacked further documentation of why the medication was not administered on the other days. 4. During an interview on 12/17/2021 at 9:50 A.M., Resident K indicated she previously had 3 nitro (nitroglycerine) patches on at the same time, but it only happened once. She did not receive her Tylenol all the time and indicated it was not given for 3-4 days. Resident K's Physician Orders, dated November 2021, indicated she was to receive Vitamin C 500 mg daily, Lorazepam (anti-anxiety medication) 0.5 mg 1 tablet at bedtime, Acetaminophen 500 mg 2 tablets every 6 hours as needed for pain or discomfort. The November Medication Administration Record indicated on 11/2, 11/3, 11/4, 11/13, 11/14 and on 11/15 the vitamin C was not available. On 11/20 the Lorazepam was not available.			

	Physician Orders, dated December 2021, indicated Resident K was to receive Famotidine (antacid) 20 mg at bed time, Donepezil (cognition enhancing medication) 10 mg 1 tablet twice a day, Oxybutynin (bladder relaxant) 5 mg 1 tablet twice a day, Sertraline (antidepressant) 100 mg 1 tablet twice a day and Acetaminophen 500 mg 2 tablets every 6 hours as needed for pain or discomfort. The Medication Administration Record indicated on 12/3/2021, the Famotidine was not administered (not given - out of medication); on 12/3/2021 the Donepezil was not administered (not given - out of medication); on 12/2021 the Oxybutynin was not administered (not given - out of medication); on 12/3/2021 the Sertraline was not administered (not given - out of medication): and on 12/3 and 12/14/2021 the Acetaminophen was not administered (not given - out of medication). 5. During an interview on 12/17/2021 at 2:44 P.M., Resident M indicated he received his medications "most of the time." A clinical record review was completed on 12/17/2021 3:02 P.M. Resident M's diagnoses included, but were not limited to: diabetes, diabetic neuropathy			

	and chronic kidney disease. Resident M's current Physician Orders indicated the resident was to receive glimepiride (anti-diabetic medication) 1 mg (milligram) 1 tablet every morning; Pantoprazole 40 mg 1 tablet twice a day; Metoprol 25 mg 1 tablet twice a day, and Metoclopram 5 mg 1 tablet every 6 hours. The Medication Administration Records, dated December 2021, indicated on 12/5 and 12/6/2021 Resident M did not received the glimepiride medication due to the medication was not available. On 12/19/2021 the medication Pantoprazole and Metoprol were not administered due to not available. On 12/20/2021 the metoclopram was not administered at 12:00 A.M. due to "resident missed 12 am dose due to missing cart keys". 6. During an interview on 12/17/2021 at 10:30 A.M., Resident P indicated she was going to start doing her own pills. She had missed her gabapentin (nerve pain medication) and was given the wrong pill a couple weeks ago. A clinical record review was completed on 12/17/2021 at 10:40 A.M. Resident P's diagnoses included, but were not limited to: diabetes, chronic			

kidney disease, glaucoma and acid reflux.

Resident P's current Physician Orders, dated December 2021, indicated the resident was to receive gabapentin 600 mg 1 tablet twice a day and Tab-a Vite (vitamin) 1 tablet every morning.

The December Medication Administration Record indicated on 12/1, 12/2, 12/6, 1/12, and 12/13/2021 Resident P did not receive the vitamin due to "not available - let resident know she needed it.

7. During a medication administration observation on 12/16/2021 at 7:26 A.M., QMA 4 was observed to go into Resident Q's room to administer medications. QMA 4 announced herself to the resident and communicated to Resident Q she had left her medications on the night stand.

Resident Q's current Physician Orders, indicated the resident was to receive Mag oxide (mineral) 400 mg 1 tablet twice a day and Meclizine (antihistamine) 25 mg 1 tablet twice a day.

A Medication Administration Record, dated December 2021, indicated Resident Q did not receive the medications mag oxide and the Meclizine on 12/15/2021 due to the

	medications were not available. 8. A clinical record review was completed on 12/17/2021 at 2:44 P.M. Resident W's diagnoses included, but were not limited to: diabetes, depression, anxiety and obesity. Resident W's current Physician Orders indicated the resident was to receive Humalog insulin per sliding scale results and another 4 units routinely four times a day. Resident W's Insulin Sheets were reviewed on 12/16/2021 and indicated the resident did not receive insulin injections on the following dates: 2 doses on 12/8/2021 and 1 dose on 12/9/2021 due to resident not in room. 9. A clinical record review was completed on 12/17/2021 at 9:28 A.M. Resident BB's diagnoses included, but were not limited to diabetes, obesity, dementia bipolar and depression. Resident BB's current Physician Orders, indicated the resident was to receive Trulicity insulin 0.5 ml (milliliter) subcutaneous every week on Thursdays.			

	The Insulin Medication Sheet, dated 12/2021, indicated the Trulicity was not administered on 12/2/2021 due to unavailable. 10. A clinical record review was completed on 12/17/2021 on 11:59 A.M. Resident CC's current diagnoses included, but were not limited to: diabetes and hypothyroidism. The current Physician's Orders for Resident CC indicated she was to receive Humalog insulin per sliding scale results. The December Medication Administration Record indicated Resident CC did not receive the insulin injections on 12/8 and 12/9 x 2 doses, and on 12/14 x 1 dose. 11. A clinical record review was completed on 12/16/2021 at 1:20 P.M. Resident DD's diagnoses included, but were not limited to: back pain, diabetes, obesity and sleep apnea. The current physician orders for Resident DD indicated he was to receive Trulicity insulin 0.5 ml subcutaneous every week. The December Medication Administration Record dated December 2021 indicated the Trulicity insulin was not administered on 12/2/2021 due to the medication was			

	unavailable. During an interview on 12/16/2021 at 8:51 A.M., QMA 4 indicated if the medications were not in the cart, they were instructed to write on the back of the medication sheet the medication was not available and report it to the nurse. QMA 4 indicated the medications were delivered every Friday night. During an interview on 12/16/2021 at 10:03 A.M., QMA 3 indicated there was no nurse on 12/8/2021 and the night shift nurse stayed over to do the insulin administrations and the evening nurse came in early. During an interview on 12/20/2021 at 10:42 A.M., the Director of Nursing indicated if a resident missed 3 doses of a medication, they were to notify the physician and get it discontinued. If the medications were not in the cart, they should call the back up pharmacy for the medications and/or call the primary pharmacy to see if it had been ordered and when it should be delivered. On 12/17/2021 at 1:50 P.M., the Director of Nursing provided the policy titled, "Medication Availability", dated 3/1/2021, and indicated the policy was the one currently used by the facility. The policy indicated"...In			

	order to most appropriately provide for the care of those residents for whom this community is administering medications, the community must have a supply of that medication ready to administer. 1. Staff members will provide ample notice to residents or power of attorney if medications are needed and the contracted pharmacy is not the preferred pharmacy. 2. If the Resident and/or the Responsible Party have not provided the medication prior to the administration of the final dose and the medication is not available in the community's EDK, the community will order the required medication from the community's contracted pharmacy provider. 3. In the event that the community is administering the last dose of a medication and the medication has not yet arrived from either pharmacy, staff will request a "stat" delivery of the medication from the contracted provider...." On 12/17/2021 at 1:51 P.M., the Director of Nursing provided the policy titled, "Ordering and Receiving Medications From Pharmacy", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...Medications and related products are received from the pharmacy on a timely basis. a). Reorder medication			

	three to four days in advance of need to assure an adequate supply is on hand...." On 12/17/2021 at 1:52 P.M., the Director of Nursing provided the policy titled, "Staff Administration Medication",dated March 1, 2021, and indicated the policy was the one currently used byte the facility. The policy indicated"...2. The Medication Sheets must be reviewed each time the medications are administered to make certain that changes have not been made or medications discontinued....8. Draw a circle around the square and initial it when the resident is observed not taking an ordered medication. Indicated on the back of the Medication Sheet the date, time, and reason the medication was not taken. The following are examples of when a resident may not take an ordered medication: A resident refuses too take a medication. Medications are sent with the resident or family members when the resident leaves the community/facility. Doctor orders that a medication temporarily not be given...." This state residential finding relates to Complaint IN00369128.			
R 0407	Infection Control - Noncompliance	R 0407	100% of residents within the	01/24/2022

	410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not having an ongoing process for documenting when testing had occurred and not informing the residents/families of new positive COVID-19 cases timely during a COVID-19 outbreak. This had the poteitial to affect all 122 residents in the facility. Finding includes: During an interview, on 12/15/2021 at 9:49 A.M., the Corporate Nurse indicated the		community, including those identified in the survey, had the potential tobe impacted by the practices of testing and communication. Residents were provided an update on thestatus of COVID within the community. All unvaccinated residents and staff will be tested weekly. All records will be maintained by the assignedteam member. (See attached Hellenic Covid testing results) All residents will be provided written notification of any positive COVID cases thatimpacts our community. Residents will be provided an opportunity to update the persons that theywould like to receive notification regarding the status of Covid in the community. Any persons whoprovide a method of communication will receive updates related to the status of Covid in thecommunity within 24 hours of a status change. All staff and residents will be aware of the requirementsfor weekly testing of unvaccinated persons as well as how they or their identified person of choice can receive COVID updates. The Executive Director will audit all weekly testing in comparison to the identified list of unvaccinated parties until weekly testing is no longer required by the Indiana Department of Health. The ExecutiveDirector or designee will audit the list of all persons to whom the residents would like to have COVIDcommunications sent. In the event a resident lists no persons to	

	facility had 3 positive residents and staff. She indicated the residents had been restricted to their rooms and had a request for the strike team to come and do testing. All the unvaccinated staff and residents are tested weekly. The Corporate nurse indicated "one resident was the first to test positive and had gone to the hospital and and passed away about 2 weeks ago before all this happened". During an interview on 12/15/21 at 4:10 P.M. the Corporate Nurse indicated she was unsure when the residents were tested last. They had let the Director of Nursing go about 3 weeks ago, and a lot of things came up missing and they could not find the resident testing documents. The Corporate nurse indicated the test dates and results should be documented in the residents' records. During an interview on 12/15/2021 at 11:30 A.M., Resident B indicated, they "are told by the grapevine when there are positive cases in the facility".. During an interview on 12/15/2021 at 12:20 P.M., the family of Resident D indicated the facility did not communicate things to her. She did not know the residents were in quarantine until she saw the notes on the door today when she visited.		receive communication, this choice willbe confirmed by the Executive Director or a designee. The Regional Director of Clinical Services willaudit resident files weekly to identify COVID cases and validate that a communication was sent toresidents and identified parties weekly. The community will be compliant by January 24, 2022.	

The family member indicated she was not notified of positive cases.

During an interview on 12/15/2021 at 3:36 P.M., Resident E indicated residents were not informed of the positive cases of Covid immediately. "We are not told if it's 3 new ones or what, they post a letter on the doors about the Covid." She indicated they started the isolation on the evening of 12/11/2021.

During an interview on 12/17/2021 at 12:07 P.M., the Administrator indicated the staff who had tested positive had been off and not worked since testing positive. She indicated 8-10 residents had been tested on 12/16/2021 and were all negative. She indicated there were no testing documents, and per the Corporate office, they were not required to do the line listings.

During an interview, on 12/17/2021 at 1:40 P.M., the Administrator indicated there had been another resident who had tested positive on 11/23/2021. The resident had been with her family and one of the family members was positive. At that time, she had sent out the note of the positive case to the residents and families. On 11/24/2021, another resident was positive.

The Administrator indicated she had sent out another note indicating there were 2 positive residents. She indicated both of the residents did not come out of their rooms. On 12/4/2021, another resident was sent to the hospital, was tested with a positive result, and later expired. On 12/3/2021 staff member 8 had been in the positive resident's room and had removed her mask. On 12/6/2021 Staff 8 was tested and had a positive result. Staff 9 had requested to be tested on 12/6/2021 and a positive result was received on 12/8/2021. On 12/7/2021, Resident GG requested to be tested and had a positive result. On 12/11/2021, Resident HH had gone to a scheduled doctor's appointment and was tested there with a positive result. On 12/8/2021, Staff 10 was tested with a positive result. On 12/10/2021, Resident JJ was sent to the hospital, was tested there with a positive result and returned to the facility on 12/14/2021.

A typed letter, dated 12/11/2021, indicated "at this time, the facility have [sic] been made aware that one staff member and 3 residents are now positive with COVID -19. All persons who have a positive diagnoses are currently off from work, quarantining in their apartments or out to the

hospital. We have attempted to trace all persons with whom the affected persons were in contact. Unfortunately, the number of those affected during the three-day period prior to becoming symptomatic is significant."

A typed letter, dated 12/14/2021, indicated, "Thank you for your patience and cooperation as we all deal the the quarantine in our community. It will soon end...on Monday, December 20th at noon. Just in time for Christmas!"

During an interview, on 12/20/2021 at 1:45 P.M., the Administrator indicated she was not in the facility when the other positive cases of COVID-19 were happening, and she was unaware if any notifications were communicated to the residents/families for the new cases after 11/24/2021.

On 12/16/2021 at 2:30 P.M., the Corporate Nurse provided a policy and procedure titled." Policy and Procedure COVID-19", dated 3/1/2021, and indicated the policy was the policy currently used by the facility. The policy indicated"... In response to the potential risk of exposure the COVID-10 or Coronavirus, this community will follow the evolving guidance of the Indiana Department of

Health as well as the Centers for Disease Control. Every effort is being made to honor the resident's rights through this process while implementing stringent infection control procedures. 1. Executive Directors will review changes to the Indiana Department of Health COVID-19 Toolkit as provided on the Indiana Department of Health Website.... 2. Executive Directors will implement all toolkit items consistent with operations in a Licensed Residential Care environment...."

Guidance for Reporting (May 2020) was retrieved on 12/17/2021 from the CMS (Centers for Medicare & Medicaid Services) website, Ref: QSO-20-29-NH. The guidance included: The guidance included "...(g) COVID-19 Reporting. The facility must-(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must-

(i) Not include personally

identifiable information;

(ii)Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and

(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other...."

This state residential finding relates to Complaint IN00369128.

Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not having an ongoing process for documenting when testing had occurred and not informing the residents/families of new positive COVID-19 cases timely during a COVID-19 outbreak. This had the poteitial to affect all 122 residents in the facility.

Finding includes:

During an interview, on 12/15/2021 at 9:49 A.M., the Corporate Nurse indicated the facility had 3 positive residents and staff. She indicated the residents had been restricted to their rooms and had a request for the strike team to come and do testing. All the unvaccinated staff and residents are tested weekly. The Corporate nurse indicated "one resident was the first to test positive and had gone to the hospital and and passed away about 2 weeks ago before all this happened".

During an interview on 12/15/21 at 4:10 P.M. the Corporate Nurse indicated she was unsure when the residents were tested last. They had let the Director of Nursing go about 3 weeks ago, and a lot of things came up missing and they could not find the resident testing documents. The Corporate nurse indicated the test dates and results should be documented in the residents' records.

During an interview on 12/15/2021 at 11:30 A.M., Resident B indicated, they "are told by the grapevine when there are positive cases in the facility"..

During an interview on 12/15/2021 at 12:20 P.M., the family of Resident D indicated

the facility did not communicate things to her. She did not know the residents were in quarantine until she saw the notes on the door today when she visited. The family member indicated she was not notified of positive cases.

During an interview on 12/15/2021 at 3:36 P.M., Resident E indicated residents were not informed of the positive cases of Covid immediately. "We are not told if it's 3 new ones or what, they post a letter on the doors about the Covid." She indicated they started the isolation on the evening of 12/11/2021.

During an interview on 12/17/2021 at 12:07 P.M., the Administrator indicated the staff who had tested positive had been off and not worked since testing positive. She indicated 8-10 residents had been tested on 12/16/2021 and were all negative. She indicated there were no testing documents, and per the Corporate office, they were not required to do the line listings.

During an interview, on 12/17/2021 at 1:40 P.M., the Administrator indicated there had been another resident who had tested positive on 11/23/2021. The resident had been with her family and one of the family members was

positive. At that time, she had sent out the note of the positive case to the residents and families. On 11/24/2021, another resident was positive. The Administrator indicated she had sent out another note indicating there were 2 positive residents. She indicated both of the residents did not come out of their rooms. On 12/4/2021, another resident was sent to the hospital, was tested with a positive result, and later expired. On 12/3/2021 staff member 8 had been in the positive resident's room and had removed her mask. On 12/6/2021 Staff 8 was tested and had a positive result. Staff 9 had requested to be tested on 12/6/2021 and a positive result was received on 12/8/2021. On 12/7/2021, Resident GG requested to be tested and had a positive result. On 12/11/2021, Resident HH had gone to a scheduled doctor's appointment and was tested there with a positive result. On 12/8/2021, Staff 10 was tested with a positive result. On 12/10/2021, Resident JJ was sent to the hospital, was tested there with a positive result and returned to the facility on 12/14/2021.

A typed letter, dated 12/11/2021, indicated "at this time, the facility have [sic] been made aware that one staff member and 3 residents are

now positive with COVID -19. All persons who have a positive diagnoses are currently off from work, quarantining in their apartments or out to the hospital. We have attempted to trace all persons with whom the affected persons were in contact. Unfortunately, the number of those affected during the three-day period prior to becoming symptomatic is significant."

A typed letter, dated 12/14/2021, indicated, "Thank you for your patience and cooperation as we all deal the the quarantine in our community. It will soon end...on Monday, December 20th at noon. Just in time for Christmas!"

During an interview, on 12/20/2021 at 1:45 P.M., the Administrator indicated she was not in the facility when the other positive cases of COVID-19 were happening, and she was unaware if any notifications were communicated to the residents/families for the new cases after 11/24/2021.

On 12/16/2021 at 2:30 P.M., the Corporate Nurse provided a policy and procedure titled." Policy and Procedure COVID-19", dated 3/1/2021, and indicated the policy was the policy currently used by the facility. The policy indicated"...

	In response to the potential risk of exposure the COVID-10 or Coronavirus, this community will follow the evolving guidance of the Indiana Department of Health as well as the Centers for Disease Control. Every effort is being made to honor the resident's rights through this process while implementing stringent infection control procedures. 1. Executive Directors will review changes to the Indiana Department of Health COVID-19 Toolkit as provided on the Indiana Department of Health Website.... 2. Executive Directors will implement all toolkit items consistent with operations in a Licensed Residential Care environment...." Guidance for Reporting (May 2020) was retrieved on 12/17/2021 from the CMS (Centers for Medicare & Medicaid Services) website, Ref: QSO-20-29-NH. The guidance included: The guidance included "...(g) COVID-19 Reporting. The facility must-(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms			

	occurring within 72 hours of each other. This information must- (i) Not include personally identifiable information; (ii)Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other...." This state residential finding relates to Complaint IN00369128.			

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 SIGNATURE	TITLE	(X6) DATE