STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEET GALILEE AT THE WIGWAM	1315 JOHN STREET, ANDERSON, , 46016

(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 Complaint IN00454065. Complaint IN00454065 - State deficiencies related to the allegations are cited at R0055. Survey date: March 13, 2025 Facility number: 014706 Residential Census: 93 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed March 21, 2025.	R 0000		
R 0055	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(y)(1-4) (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following:	R 0055	1 No adverse effect noted to residents C, E and F. The staff member received written disciplinary action and was immediately retrained on Residents' Rights	04/14/2025

(1) Bathing.

(2) Personal care.

(3) Physical examinations and treatments.

(4) Visitations.

Based on interview and record review, the facility failed to protect resident privacy by allowing a night shift staff member to enter resident rooms without permission for 3 of 6 residents reviewed for resident rights. (Residents C, E, and F)

Findings included:

1. During an interview on 3/13/25 at 1:00 p.m., Resident C indicated the night guard had entered her room at night regularly without knocking or having a reason to be there. This past Saturday night, 3/8/25, the night guard was in her room between 2:30 a.m. and 3:30 a.m. Resident C had woken up and called out "who is there?" The night guard replied that "it's just me, checking on you." Resident C indicated she again asked her not to enter her room anymore. The night guard would also accompany the care staff when the call light was answered. Resident C had asked her to leave when she was receiving assistance from the care staff and the night guard would become upset. She

2 The
deficiency had the potential to affect all Residents.

3 The
Executive Director will provide in-service training to all staff on Residents'
Rights on 4/8/25 .
Audit/Interviews will be conducted by the Executive Director to
ensure staff are not entering resident apartments without permission weekly x 4
weeks then monthly x 5 months.

4 Audit
findings will be reported to the QAPI committee for the next 6 months. Negative
variances will be corrected at the time of discovery and reported to the
community's QAPI committee.

5

felt the night guard had no business in being present in resident rooms with care staff.

Resident C's clinical record was reviewed on 3/13/25 at 1:18 p.m. Diagnoses included anxiety, heart failure, and diabetes mellitus type 2.

A Level of Service Assessment, completed 1/28/25, indicated the resident understood information conveyed without difficulty and was able to communicate information and was understood. The resident would not require care from another person during the night. She required direct assistance from another person for parts of dressing and undressing and required assistance with minimal parts of bathing

2. During an interview on 3/13/25 at 10:46 a.m., Resident E indicated he had a problem with the night guard entering his room every night without knocking or having a reason to enter. He indicated it was usually around 1:00 a.m. to 2:00 a.m. It would frighten him to have someone just walk in his room. The night guard indicated she could enter his room anytime at night to complete a facility census.

Resident E's clinical record was reviewed on 3/13/25 at 11:29 a.m. Diagnoses included

chronic obstructive lung disease, chronic kidney disease, and angina.

A Level of Service Assessment, completed 2/4/25, indicated the resident understood information conveyed without difficulty and was able to communicate information and was understood. The resident would not require care from another person during the night. He would not require assistance for his activities of daily living.

3. During an interview on 3/13/25 at 11:03 a.m., Resident F indicated the night guard would enter his room almost every night. He had asked her not to enter his room at night. On occasion his girlfriend would spend the night, and the night guard would enter his room without knocking and indicate, "she's got to go." His girlfriend had signed in as required for overnight guests, but she still had to leave.

Resident F's clinical record was completed on 3/13/25 at 11:44 a.m. Diagnoses included major depression, anxiety disorder, and insomnia.

A Level of Service Assessment, completed 2/4/25, indicated the resident understood information conveyed without difficulty and was able to communicate information and was

understood. The resident would not require care from another person during the night. He required staff assistance with minimal parts of bathing, but required no other assistance with activities of daily living.

During an interview on 3/13/25 at 5:30 a.m., the night guard indicated she toured the building for rounds, but was usually at the desk most of her shift. She had not entered resident rooms unless she had a reason. The Administrator had directed her not to continue to enter resident rooms to complete census.

During an interview on 3/13/25 at 6:42 a.m., the Administrator indicated the night guard was already an employee when she became the administrator at the facility, and there had been the practice of her entering an apartment without permission to complete census at night. This had been the policy prior to her becoming the Administrator. She's not sure how long ago, she ceased the practice of taking census at night and instructed the night guard to cease entering resident apartments without permission. She had not reviewed the surveillance footage to assure the night guard had not continued to enter resident apartments without cause.

During an interview on 3/13/25 at 10:01 a.m., the Administrator indicated she was not aware the night guard had continued to enter rooms at night or to accompany care staff into resident apartments.

A current facility policy, revised 12/2024, titled, "Resident's Personal Rights Policy and Procedure," provided by the Administrator on 3/13/25 at 1:00 p.m., included: "....Each resident will have the right to:...5. Have his or her privacy respected."

A current copy of the facility "Resident Lease Agreement," provided by the Administrator on 3/13/25 at 1:19 p.m., included the following: "...D. Use and Maintenance of Your Unit...9. Access: The Owner, Management Agent or Service Provider will give you not less than 24-hour notice of their intent to enter the Unit, except in case of an emergency threatening physical damage or loss to the Unit, or a medical emergency...."

This citation relates to Complaint IN00454065.

Based on interview and record review, the facility failed to protect resident privacy by allowing a night shift staff member to enter resident rooms without permission for 3 of 6 residents reviewed for resident

rights. (Residents C, E, and F)

Findings included:

1. During an interview on 3/13/25 at 1:00 p.m., Resident C indicated the night guard had entered her room at night regularly without knocking or having a reason to be there. This past Saturday night, 3/8/25, the night guard was in her room between 2:30 a.m. and 3:30 a.m. Resident C had woken up and called out "who is there?" The night guard replied that "it's just me, checking on you." Resident C indicated she again asked her not to enter her room anymore. The night guard would also accompany the care staff when the call light was answered. Resident C had asked her to leave when she was receiving assistance from the care staff and the night guard would become upset. She felt the night guard had no business in being present in resident rooms with care staff.

Resident C's clinical record was reviewed on 3/13/25 at 1:18 p.m. Diagnoses included anxiety, heart failure, and diabetes mellitus type 2.

A Level of Service Assessment, completed 1/28/25, indicated the resident understood information conveyed without difficulty and was able to communicate information and

was understood. The resident would not require care from another person during the night. She required direct assistance from another person for parts of dressing and undressing and required assistance with minimal parts of bathing

2. During an interview on 3/13/25 at 10:46 a.m., Resident E indicated he had a problem with the night guard entering his room every night without knocking or having a reason to enter. He indicated it was usually around 1:00 a.m. to 2:00 a.m. It would frighten him to have someone just walk in his room. The night guard indicated she could enter his room anytime at night to complete a facility census.

Resident E's clinical record was reviewed on 3/13/25 at 11:29 a.m. Diagnoses included chronic obstructive lung disease, chronic kidney disease, and angina.

A Level of Service Assessment, completed 2/4/25, indicated the resident understood information conveyed without difficulty and was able to communicate information and was understood. The resident would not require care from another person during the night. He would not require assistance for his activities of daily living.

3. During an interview on 3/13/25 at 11:03 a.m., Resident F indicated the night guard would enter his room almost every night. He had asked her not to enter his room at night. On occasion his girlfriend would spend the night, and the night guard would enter his room without knocking and indicate, "she's got to go." His girlfriend had signed in as required for overnight guests, but she still had to leave.

Resident F's clinical record was completed on 3/13/25 at 11:44 a.m. Diagnoses included major depression, anxiety disorder, and insomnia.

A Level of Service Assessment, completed 2/4/25, indicated the resident understood information conveyed without difficulty and was able to communicate information and was understood. The resident would not require care from another person during the night. He required staff assistance with minimal parts of bathing, but required no other assistance with activities of daily living.

During an interview on 3/13/25 at 5:30 a.m., the night guard indicated she toured the building for rounds, but was usually at the desk most of her shift. She had not entered resident rooms unless she had a reason. The Administrator had

	directed her not to continue to enter resident rooms to complete census. During an interview on 3/13/25 at 6:42 a.m., the Administrator indicated the night guard was already an employee when she became the administrator at the facility, and there had been the practice of her entering an apartment without permission to complete census at night. This had been the policy prior to her becoming the Administrator. She's not sure how long ago, she ceased the practice of taking census at night and instructed the night guard to cease entering resident apartments without permission. She had not reviewed the surveillance footage to assure the night guard had not continued to enter resident apartments without cause. During an interview on 3/13/25 at 10:01 a.m., the Administrator indicated she was not aware the night guard had continued to enter rooms at night or to accompany care staff into resident apartments.			

	A current facility policy, revised 12/2024, titled, "Resident's Personal Rights Policy and Procedure," provided by the Administrator on 3/13/25 at 1:00 p.m., included: "....Each resident will have the right to:...5. Have his or her privacy respected." A current copy of the facility "Resident Lease Agreement," provided by the Administrator on 3/13/25 at 1:19 p.m., included the following: "...D. Use and Maintenance of Your Unit...9. Access: The Owner, Management Agent or Service Provider will give you not less than 24-hour notice of their intent to enter the Unit, except in case of an emergency threatening physical damage or loss to the Unit, or a medical emergency...." This citation relates to Complaint IN00454065.			

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