PRINTED: 01/23/2023 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155754 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 12/21/2022 | | | |
|---|--|---|--|--|--|----------------------|------------|--|
| NAME OF PROVIDER OR SUPPLIER HUBBARD HILL ESTATES INC | | | | STREET ADDRESS, CITY, STATE, ZIP COD 28070 CR 24 ELKHART, IN 46517 | | | | |
| (X4) ID PREFIX TAG R 0000 | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE | | |
| Bldg. 00 | This visit was for the Investigation of Complaint IN00397056. Complaint IN00397056 - Substantiated. State deficiencies related to the allegations are cited at R0027. Survey date: 12/21/22 Facility number: 001131 Residential Census: 116 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 12/27/22. | | R 00 | 000 | | | | |
| R 0027 Bldg. 00 | existence, self-de communication w and services insid Residents have the rights as a resident citizen or resident Based on observation review, the facility were ensured for the households in the L Care (Tudor). Findings include: On 12/21/22 from 1 | - Deficiency e the right to a dignified | R 0 | 027 | Survey date: 12/21/22 Fact 001131 Complaint survey #IN0039705 State finding R 027 410IAC 16.2-5-1.2b What corrective action will be done by the facility? Effective 1/5/23 the Living Wis Center has changed its' quarantine practice to reflect the | dom | 01/08/2023 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Terry L Schollmeier COO/LNHA 01/05/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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.

State Form Event ID: PS0X11 Facility ID: 001131 If continuation sheet Page 1 of 4

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | |
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| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> CO | | COMPL | ETED | |
| | | 155754 | B. WING | | 12/21/ | 12/21/2022 | |
| | | | | CTREET | ADDRESS SITY STATE ZIR COD | | |
| NAME OF F | PROVIDER OR SUPPLIER | 8 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | 28070 (| | | |
| HUBBAR | RD HILL ESTATES I | NC | | ELKHA | RT, IN 46517 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRECTION | | | | (X5) |
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| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION | | | TAG | DEFICIENCY) | | DATE |
| | noted to have Contact Isolation signs at the entry | | | | during times of Covid-19 | | |
| | doors of Tudor unit | . Carts with Personal | | | quarantine, negative residents | will | |
| | Protective Equipme | ent were at observed outside | | be permitted to leave f | | or | |
| | the unit. | | | | visits or LOAs as requested by | / | |
| | | | | | resident or legal representative | e. | |
| | On 12/21/22 at 2:00 | P.M., an interview with Living | | | The Living Wisdom Center Dir | ector | |
| | Wisdom Memory C | Care Program Director, indicated | | | or Clinical Manager will ensure | 9 | |
| | when any resident v | who resided in 1 of the 4 Living | | | legal representatives are educ | | |
| | Wisdom Memory C | Care units tested positive for | | | regarding the risk of outside | | |
| | COVID-19, the who | ole unit would be isolated. The | | | facility visits/LOAs with a | | |
| | Living Wisdom Me | emory Care Program Director | | | dementia resident who has ha | ad | |
| | indicated they curre | ently had one resident positive | | | an exposure and their limited | | |
| | for COVID-19 on T | Sudor so the entire unit was | | | cognitive ability to understand | the | |
| | under quarantine, as | nd indicated no residents | | | need for masking or safe | | |
| | Tudor were allowed | to leave the facility for visits | | | distancing from others. This | | |
| | home or for leaves | of absence (LOA). The Living | | | education when completed wil | l be | |
| | Wisdom Memory C | Care Program Director indicated | | | documented in the resident's | | |
| | the unit would remain under quarantine until | | | | nurses notes in medical record | d. | |
| | every resident was out of quarantine. | | | | _ | | |
| | | | | | How will the facility identify oth | <u>ner</u> | |
| | On 12/21/22 at 2:17 | P.M., an interview with the | | | residents having the potential | <u>to</u> | |
| | Director of Nursing | indicated Tudor was the only | | | be affected by the same pract | ice_ | |
| household who was currently deni | | currently denied LOA | | | and what corrective action will | be | |
| | because there was still one resident who was | | | | taken? | | |
| | positive for COVID | 0-19. The Director of Nursing | | | Currently, all four houses in th | е | |
| | indicated any time 1 resident tested positive for | | | | Living Wisdom Center are ope | en | |
| | COVID-19, the enti | ire unit would be placed in | | | and free of any Covid-19 posit | tive | |
| | isolation and those residents would not be | | | | individuals. All of the Living | | |
| | allowed LOA even if they tested negative. | | | | Wisdom residents' legal | | |
| | | | | | representatives have been no | tified | |
| | On 12/21/22 at 2:25 | P.M., an interview with the | | | via e-mail on 1/5/23 of the cha | inge | |
| | Administrator indic | ated residents who lived in | | | in quarantine practice and tha | t any | |
| | Living Wisdom who | ere difficult to isolate to their | | | negative resident living in a | | |
| | rooms, so for the sa | fety of the residents and the | | | Covid-19+ quarantined house | will | |
| | | the practice of the facility to | | | be permitted to have visits/LO | As | |
| isolate the unit when a resident tests positive for | | | | outside the facility as requeste | ed | | |
| | COVID-19. The A | dministrator indicated residents | | | by the resident or legal | | |
| | who resided on unit | s that had COVID-19 positive | | | representative. | | |
| | residents were aske | d to remain in the facility and | | | <u>-</u> | | |
| | were not to go LOA | ۸. | | | What measures will be put into | <u>) </u> | |

State Form Event ID: PS0X11 Facility ID: 001131 If continuation sheet Page 2 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2023 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155754 | | A. BUILDING 00 B. WING | | COMPLETED 12/21/2022 | | | |
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| | provided the form, indicating it was the policy, which indict to a dignified existe communication wit services inside and resident has a right the community and activities both inside | P.M., the Director of Nursing "Resident Rights," dated 8/22, e current Resident Rights ated, "The resident has a right ence, self-determination, and h and access to persons and outside the facilityThe to interact with members of participate in community e and outside the facility" elates to complaint IN00397056. | | place to ensure this practice of not recur? 1. Education of the Living Wisdom staff regarding this change in quarantine practice the review of the resident's righter for visits/ LOAs was complete 1/5-1/6/23. 2. Living Wisdom Center residents' legal representative were notified by the Living W Center Director of the change our quarantine practice to allout of facility visits/ LOAs on 1/5/23. 3. The Living Wisdom Cer Director and Clinical Manage monitor the resident sign in-ologs weekly during times of quarantine, to ensure staff compliance for requested out facility visits/ LOAs. How will corrective action be monitored to ensure the deficing practice does not recur and weekly during time quarantine by the Living Wisdom Center Director/or Clinical Manager to ensure residents being permitted to have out-of-facility visits or LOAs a requested. These logs will be reviewed weekly and initialed COO/HFA at the LWC team management meetings throug 3/31/23. Any issues or conceing regarding compliance with this position. | e and ghts ed on es isdom e in ow et in | | |
| | I | | I | 1 | | | |

State Form Event ID: PS0X11 Facility ID: 001131 If continuation sheet Page 3 of 4

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| | | | | practice will be discussed and resolved. The resolution will b documented in the individual resident's record as is appropr | e | |

State Form Event ID: PS0X11 Facility ID: 001131 If continuation sheet Page 4 of 4