STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155796	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation and record review, the facility failed to ensure 4 of 4 staff were wearing face shields on the Covid-19 hall (CNA 5, CNA 7, QMA 6, RN 4). Findings include During an observation on the Covid-19 hall on 9/21/2020 at 2:30 P.M., certified nursing assistants (CNAs) 5 and 7, QMA 6,and RN 4, were not wearing a face shields. CNA 5 was passing ice water to the residents. Signs on each door indicated the following personal protective equipment were to be worn Mask, Face shield, Gloves, Gown. During an interview on 9/21/2020 at 3:04 P.M., RN 3 indicated the staff on the Covid-19 hall were to be wearing face shields. 3.1-18(b)(6)
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to notify the resident's representative of a COVID-19 positive test result in 1 of 3 residents reviewed for Covid-19 test results (Resident B). Finding include: The Clinical Record of Resident B reviewed on 9/21/20 at 11:20 A.M., indicated the resident had [DIAGNOSES REDACTED]. The laboratory test results, dated 9/5/20 at 10:09 A.M., indicated Resident B was positive for COVID-19. The Progress Notes, dated 9/5/20 at 3:00 P.M., indicated the following: The social worker had attempted to notify all 3 Power Of Attorney's (POA) for Resident B of his positive COVID-19 test result. There was no documentation Resident B's POA's had returned the social worker's phone call. On 9/21/20 at 12:16 P.M., during an interview, Registered Nurse (RN) 3 indicated the following: Either the nursing department or social services should had notified the resident's family of the positive COVID-19 test result and should had documented in the resident's chart. A policy titled Prevention of COVID-19, dated 3/3/20, provided by RN 3 on 9/21/2020 at 12:40 P.M., lacked documentation in the policy that indicated the resident's representative should had been notified of a positive COVID-19 test result. On 9/21/20 at 2:25 P.M., during an interview, RN 3 indicated the policy titled Prevention of Covid-19 was the most current policy used by the facility.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.