STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155357	A. BUILDING _____ B. WING _____	**04/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RAWLINS HOUSE HEALTH & LIVING COMMUNITY	**300 J H WALKER DR PENDLETON, IN 46064**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to discontinue communal dining associated with a global pandemic of an infectious disease, in 1 of 2 dining rooms observed (Cherished Memories). Findings include: During a tour of the Cherished Memories unit, on 4/16/20 and accompanied by Nurse 7, the residents were sitting in the dining room for lunch. The square-shaped tables, with a capacity for four residents at a table, had three and four residents sitting at each table, 26 residents in total were in the dining room. She indicated the residents received their meals in the dining room, the residents were not socially distanced with at least six feet between them, if a resident coughed or sneezed at the table, and other residents sitting at that same table could be affected by respiratory droplets expelled during a cough or sneeze. The Administrator arrived on the unit during this meal time, he indicated they had previously tried serving residents in their room but the residents enjoyed the social interactions during meals in the dining room, he indicated he was aware of the guidance issued from the the Indiana State Department of Health (ISDH) to cancel all group activities and communal dining, and was aware that residents could be positive for the COVID-19 virus without showing any signs or symptoms. The campus had five residents that had been transferred to the hospital, all of the residents had been tested for [MEDICAL CONDITION] at the hospital, four residents tested positive for [MEDICAL CONDITION], one had passed away, and one resident's test results were pending. There was one employee that had tested positive for [MEDICAL CONDITION] and one employee's test results were pending. This Federal Tag relates to complaint IN 689. 3.1-18(a)

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.