STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155708	A. BUILDING _____ B. WING _____	**10/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSIDE MANOR NURSING HOME	**1109 E NATIONAL HIGHWAY WASHINGTON, IN 47501**

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 0886 **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 interview and record review, the facility failed to ensure required testing documentation was recorded to help identify and prevent the transmission of COVID-19. A Resident's record did not contain documentation that included COVID-19 testing status, physician's order for COVID-19 testing, testing dates, and results of the tests for 1 of 3 residents' records reviewed. (Resident 5) Finding includes: During an interview on 10/21/20 at 11:30 A.M., the Facility Administrator indicated Resident 5 leaves the facility routinely for [MEDICAL CONDITION] treatments and the Resident was tested twice weekly for COVID-19. During record review on 10/21/20 at 1:20 P.M., Resident 5's physician's orders did not include COVID-19 testing. No testing documentation or nurse's notes that indicated Resident 5 had received COVID-19 testing were included in the record. During an interview on 10/21/20 at 2:10 P.M., the Facility Administrator indicated an order for [REDACTED]. The Administrator indicated the facility follows COVID-19 guidelines set by CMS (Centers for Medicare and Medicaid Services), CDC (Centers for Disease Control and Prevention), and the Indiana Department of Health. 3.1-18(b)(5) 3.1-49(j)(1) 3.1-49(j)(4)

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.