STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for Investigation of Complaints IN00365461 and IN00365465. This visit included a COVID-19 Focused Infection Control Survey. This visit resulted in Immediate Jeopardy. Complaint IN00365461 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880, F883, and F887. Complaint IN00365465 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880, F883, and F887. Survey dates: October 26, 27, 28, and 29, 2021 Facility number: 000360 Provider number: 155733 AIM number: 100290370 Census Bed Type: SNF/NF: 34 Total: 34 Census Payor Type: Medicare: 18 Medicaid: 11 Other: 5 Total: 34 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/3/21.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective November 26, 2021 to the complaint survey completed on October 29,2021.	

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

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F 0880 SS=L Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;			

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	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not monitoring to make sure Agency Nursing staff were being tested for COVID-19 per the county positivity rate and tested for COVID-19 before and after	F 0880	**F880** It is the practice of this facility to assure that all procedures and services are conducted in a manner that is in accordance with infection control guidelines. **The correction action taken for those residents found to be**	11/26/2021

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	the facility's outbreak started. The facility was unaware of any testing results of the Agency Staff who had been tested prior and after the outbreak occurred. The facility also failed to notify the Agency staff who worked in the facility prior to the outbreak and the Staffing Agency of the outbreak, which places the Agency staff, the facility and other facilities where the staff work at risk. Numerous Agency Staff as well as Facility Staff indicated they had not been screened for COVID-19 upon entering the building and review of the Screening Logs indicated not every person who entered the building was screened for COVID-19, which placed the 40 residents who were residing in the facility at risk for the COVID-19 virus. There were currently 35 COVID-19 positive residents, 6 of those residents were hospitalized and 3 of the residents remain in the hospital. The immediate jeopardy began on 10/17/21 when the first resident in the facility tested positive and the facility did not require a current negative test result from the Agency Staff nor tested the Agency Staff for COVID-19 prior to working. The facility also had not ensured all staff working in the facility were screened for for COVID-19 prior to entering the resident care areas. This placed 40 of 40 residents at risk for contacting the COVID-19 virus. The Administrator and Director of Nursing (DON) were notified of the immediate jeopardy on 10/28/21 at 9:41 a.m. The immediate jeopardy was removed on 10/29/21, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility also failed to have an ongoing surveillance program in place to identify		**affected by the deficient practice include:** A screener was put in place during all shift changes to assure that all staff are screen appropriately prior to entering the building. The Infection Control Surveillance Log was reviewed and brought up to date by the Director of Nursing completing up to the current month of November 2021. The Log remains current. Resident B and C were moved to Red Zone immediately upon the discovery while the surveyor was in the building. The agency group was notified of facility outbreak status All agency staff were tested and continue to be tested each day they work. **Other residents that have the potential to be affected have been identified by**: Potentially all residents could be affected by employees, contractors, and caregivers not being properly screened. A screener is in place for all shift changes to assure all screened prior to entering the building. All residents in the building were reviewed to ensure that they were in the proper zone. No other moves were required. A facility-wide assessment was completed to assure that all residents with symptoms or covid positive status are included on the	

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	communicable diseases and infections in the Infection Control Program, which had the potential to affect 34 of 34 residents who currently reside in the facility. The facility failed to identify 2 resident rooms in the Yellow Zone (potential risk for COVID-19), as having positive COVID-19 residents residing in the rooms for 2 of 2 residents, who resided in the rooms. (Residents B & C) Findings include: 1. During an interview on 10/26/21 at 9 a.m., the Administrator indicated there were 27 residents and 13 employees currently positive for COVID-19. The outbreak started on 10/17/21 when the first resident tested positive. During an interview on 10/26/21 at 10:55 a.m., Agency Staff 1 indicated she had not been tested for COVID-19 for "a week or so". She scheduled her own testing and had not been tested by the facility. During an interview on 10/26/21 at 1:30 p.m., Agency Staff 2 & 3 were working the COVID-19 Unit. Agency Staff 2 indicated she worked at another facility and had tested negative for COVID-19 on 10/25/21. Agency Staff 3 indicated she had tested herself 10/25/21 and was negative. The Nursing Schedules, dated October 3 through the 27, 2021, were reviewed on 10/27/21 at 12:44 p.m., and indicated there were nine Agency Staff who had been scheduled and worked during these dates. The COVID-19 testing logs dated, October 3		surveillance log. All agency staff are being tested for covid each time they work. The agency group is aware of facility outbreak status. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Screening for signs and symptoms will be conducted when facility staff, including agency, enters the facility. A designated screener has been assigned for shift changes to assure that all staff are screened appropriately upon entering. All staff, including agency staff, will be in-serviced related to the requirement of screening prior to entering into the facility. The training includes not entering the building until they have been screened. All staff, including agency, have been in-serviced related to testing based on the community positivity rate or outbreak status. Agency staff will be tested prior to starting their shift each time they work. In addition, the staffing agency has been made aware of the outbreak status. Nursing staff have been in-serviced related to assuring that any resident that test positive for covid is moved to the red zone promptly based on the algorithm of symptoms and known exposure.	

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	through October 27, 2021, indicated Agency Staff 4 had worked at the facility on October 4, 5, 6, 9, 10, and 14, 2021 and had tested negative for COVID-19 on 10/5/21, 10/6/21, 10/9/21, and 10/22/21. Agency Staff 7 had had worked 10/5/21 at the facility and had tested negative for COVID-19 on 10/5/21. During an interview on 10/27/21 at 10:55 a.m., the Director of Nursing (DON) indicated she was unaware of the Agency Staff COVID-19 testing status and unsure if they were being tested twice a week. There was no policy she was aware of for Agency Staff to be tested for COVID-19. During an interview on 10/27/21 at 2:10 p.m., the Administrator indicated the Staffing Agency had not been notified of the COVID-19 outbreak. He indicated when staff were requested, there was a box to check that indicated COVID-19 was in the building. The Staffing Agency had not been notified for contact tracing. He was unsure the Staffing Agency had any results of their employee testing. During an interview on 10/28/21 at 11:18 a.m., the Administrator indicated the Agency Staff had not been tested previously. Agency Staff 5 had tested negative for COVID-19 at the facility on 10/26/21, and when tested for COVID-19 on 10/27/21, she tested positive. During an interview on 10/26/21 at 10:55 a.m., Agency Staff 1 indicated she had not been screened for COVID-19 when she entered the building on 10/26/21. During an interview on 10/26/21 at 1:30 p.m., Agency Staff 2 & 3 both indicated they had not been screened upon entering the building. They		The DON has been in-serviced related to assuring that the Infection Control Surveillance Log is kept current related to individuals showing symptoms or testing positive for Covid for tracking and trending. The nurses were in-serviced related who to report infections to so that they can be tracked, trended, and surveilled. The DON, or designee, will provide daily system monitoring and daily visual rounds to assure that infection control measures are in place A consulting Infection Preventionist from QSource performed a root cause analysis of the areas identified in the tag. The outcome is in the attached document. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** In addition to the daily rounds and monitoring for a minimum of 3 months or until substantial compliance is achieved, a Quality Assurance tool has been developed and implemented to monitor the compliance of infection control. The tool reviews the screening tool to assure that employees, including agency, are screened and no one enters the building without proper screening for signs/symptoms of covid. This tool will also audit for agency	

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	had been let in the building by the Night Shift Nurse. During an interview on 10/26/21 at 2 p.m., Facility Staff 6, indicated she had not been screened for COVID-19 when she entered the building. Review of random Screening Logs, dated 10/23/21, 10/24/21, and 10/26/21, was completed with the DON present on on 10/26/21 at 3 p.m. There were 8 of 16 staff scheduled on 10/23/23, 5 of 14 staff scheduled on 10/24/21, and 8 of 12 staff scheduled on 10/26/21 (day and evening shift), not screened for COVID-19. An undated policy, titled, "COVID Testing Guidance", received from the Administrator on 10/27/21 at 11:46 a.m., indicated screening of all facility staff, including contractors and caregivers, would be done each day. Outbreak testing of all staff who are negative would occur every 3-7 days until the testing identified no new cases of COVID-19 for 14 days. The immediate jeopardy that began on 10/17/21 was removed on 10/29/21 when the facility had inserviced 20 of the 46 facility staff and had implemented screening and testing for COVID-19 for Agency staff who had worked after the immediate jeopardy notification on 10/28/21. All Agency staff will be tested prior to their shift to work. Staff were interviewed and indicated they are to be screened prior to starting their scheduled shift, where the screening was to be done, and what to do if someone is not present in the area to screen them. The facility staff indicated they are tested twice a week and the Agency staff indicated they are to be tested before each scheduled shift. All staff scheduled		testing to assure that they receive a POC prior to being assigned to resident care. In addition, the tool will review to assure that any resident that tested positive for covid is moved promptly. Also, the tool reviews the surveillance log to assure updated and current for tracking/trendeing and that the contract agency group is aware of outbreak status. This tool will be completed by the administrator, or designee, daily x2 weeks, weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or may be increased by Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools **The date the systemic changes will be completed:** November 26, 2021	

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	for 10/28/21 and 10/29/21 had been screened and Agency staff had been tested prior to their scheduled shift. The noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility still needed to inservice 26 more of their staff and any new Agency employee scheduled to work. The facility will continue to audit the screening and testing of employees to ensure all policy and procedures are followed. 2. Review of the Infection Control Surveillance Log indicated the last surveillance of any infections in the facility was dated July 2021. During an interview on 10/27/21 at 10:55 a.m., the Director of Nursing indicated the infection surveillance logs had not been completed since July. An, "Infection Control Policy", dated 10/2017, received from the Administrator as current, indicated, "...By collecting , analyzing, and trending data, actions can be instituted to improve resident outcomes...Monitor for occurrence of infection.....Surveillance of Infections - ongoing monitoring for occurrence of infections for all residents..". 3. During an observation of the C-Hall on 10/26/21 at 10:42 a.m., the resident rooms were identified as "Yellow Zone", by signs posted outside each door. There were no signs posted outside of Resident B and C's rooms that indicated the COVID-19 status of the residents. Agency Staff 1 indicated Residents B and C tested COVID-19 positive and the residents were getting ready to be moved to the Red Zone			

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	(COVID-19 Positive). A Social Service Progress Note, dated 10/25/21 at 1:39 p.m., indicated Resident C had tested positive and would be transferred to the Red Zone. A Social Service Progress Note, dated 10/25/21 at 1:54 p.m., indicated Resident B had tested positive and would be transferred to the Red Zone. During an interview on 10/26/21 at 11:16 a.m., the Administrator indicated there were no signs posted which indicated Resident B and C were positive for COVID-19 because they were supposed to be transferred to the rooms open in the Red Zone on 10/25/21. The staff had not yet transferred them to the rooms. This Federal tag relates to Complaints IN00365461 and IN00365465. 3.1-18(a) 3.1-18(b)(1)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31			

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	annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side			

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	effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on record review and interview, the facility failed to ensure a resident received the pneumococcal immunization after the Responsible Party had consented for the pneumococcal immunization to be given for 1 of 5 residents reviewed for influenza and pneumococcal immunizations. (Resident D) Finding includes: Resident D's record was reviewed on 10/27/21 at 9:24 a.m. The diagnoses included, but were not limited to, Parkinson's disease and diabetes mellitus. The admission date into the facility was 8/12/21. The, "Consent to Administer the Influenza Vaccination and the Pneumococcal Vaccination", form was signed by the Resident Representative on 8/11/21. The Influenza Vaccination was administered on 10/15/21. The Pneumococcal Vaccination had not been administered. During an interview on 10/27/21 at 10:55 a.m., the Director of Nursing (DON) indicated the pneumococcal vaccination had not been given. This Federal tag relates to Complaints IN00365461 and IN00365465.	F 0883	**F883** It is the practice of this facility to assure that immunizations are offered and administered based on the resident choices. **The correction action taken for those residents found to be affected by the deficient practice include:** Residents D will be administered the pneumovax per their consent once the resident is recovered from covid and the physician is in agreement. **Other residents that have the potential to be affected have been identified by**: A facility wide audit was completed to determine the resident's Pneumococcal Immunization status to assure that if the resident (or resident representative) consented to the vaccine, that it has been administered or will be once the resident is recovered from covid based on physician agreement. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** The Department Heads and nurses have been in-serviced related to the residents identifying	11/26/2021

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			consent or declination at the time of admission based on educational information that has been provided to them related to the pneumonia vaccine. During routine morning clinical meetings, new admissions will be reviewed by the IDT to assure that the resident or resident representative have made a documented decision for either consent or declination related to the Pneumonia vaccine. For those residents that consented to the vaccine, the IDT will follow until administered. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Quality Assurance tool has been developed and implemented to monitor the compliance of residents (resident representatives) making informed decision related to the Pneumococcal vaccine. The tool reviews residents to assure that any resident consenting to the pneumonia vaccine receives the vaccine. This tool will be completed by the DON, or designee, weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Additional action will be	

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			taken by the Quality Assurance Committee if warranted based on the outcome of tools **The date the systemic changes will be completed:** November 26, 2021	
F 0887 SS=J Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept			

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	155733	A. BUILDING 00 B. WING	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

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	or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on record review and interview, the facility failed to ensure the COVID-19 vaccination was offered to all residents of the facility, related to 2 of 40 residents who were not offered the COVID-19 vaccine after admission. (Residents D and E) Both residents have now tested positive for COVID-19. Resident D had the first positive COVID-19 test on 10/17/21 after presenting with a non-productive cough with diminished lung sounds and was transferred to the Emergency Room for hypoxia. Resident E tested positive on	F 0887	**F887** It is the practice of this facility to assure that all residents are offered the Covid vaccination at the time of admission **The correction action taken for those residents found to be affected by the deficient practice include:** Residents E and D (or resident representative) identified have been approached and	11/26/2021

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	10/18/21. There are now 35 COVID-19 positive residents, of which 6 have been hospitalized, with 3 of those 6 residents remaining in the hospital, and 13 COVID-19 positive staff in the facility. The immediate jeopardy began on 5/27/21 when the facility failed to offer the COVID-19 vaccination on admission to Resident E and failed to offer the COVID-19 vaccination to Resident D when admitted on 8/12/21. This placed the two residents at a risk for serious harm, serious impairment, or death related to the contracting the COVID-19 virus. The Administrator and Director of Nursing (DON) were notified of the immediate jeopardy on 10/28/21 at 9:41 a.m. The immediate jeopardy was removed on 10/29/21, but noncompliance remained at the lower scope and severity level of actual harm that is not immediate jeopardy. Findings include: 1. During an interview on 10/26/21 at 9:30 a.m., the Administrator indicated Resident E tested positive for COVID-19 on 10/20/21 and had a cough and lung congestion. Resident E's record was reviewed on 10/27/21 at 12:27 a.m. The diagnoses included, but were not limited to, Dementia. The admission dated was 5/27/21. An Undated, "Consent to Administer the Influenza Vaccination and the Pneumococcal Vaccination", form was signed by the Health Care Representative. The form was documented as effective on 6/2/21 in the record. The Influenza Vaccination was administered on		documentation is present of either consent or declination of the covid vaccine. **Other residents that have the potential to be affected have been identified by:** All residents were reviewed related to assuring that there is a consent or declination of the covid vaccine. No additional concerns were noted. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** The Department Heads and nurses have been in-serviced related to the residents identifying consent or declination at the time of admission based on education information that has been provided to them related to the Covid Vaccination. During routine morning clinical meetings, new admissions will be reviewed by the IDT to assure that the resident or resident representative have made a documented decision for either consent or declination related to the covid vaccine. The consent for covid vaccination has also been added to the resident admission packet to start the process. The DON, or designee, will provide daily system monitoring and daily visual rounds to assure that infection control measures are in place related to vaccine administration	

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	10/15/21. The Pneumococcal Vaccination had been administered on 6/16/21. There were no consent or declination forms signed for the COVID-19 vaccination in the record. A Nurse's Progress Note, dated 10/20/21 at 2:20 p.m., indicated the resident was not feeling well, was not wanting to eat and had an episode of diarrhea. A Rapid COVID-19 test was administered and resulted as positive. During an interview on 10/27/21 at 10:35 a.m., the Administrator indicated there was no declination or consent for the COVID-19 Vaccination. During an interview on 10/27/21 at 10:55 a.m., the Director of Nursing (DON) indicated the COVID-19 Vaccine had not been offered. A Nurse's Progress note, dated 10/27/21 at 11:24 a.m., indicated the Health Care Representative was notified about the COVID-19 Vaccine and informed the facility that due the resident being unable to leave the house prior to admission into the facility, she was unable to be vaccinated and consent was given to vaccinate the resident with the COVID-19 vaccine when it would be available and she would be eligible to have it. 2. Resident D's record was reviewed on 10/27/21 at 9:24 a.m. The diagnoses included, but were not limited to, Parkinson's disease and diabetes mellitus. The admission date into the facility was 8/12/21.		**The corrective action taken to monitor performance to assure compliance through quality assurance is:** In addition to the daily rounds and monitoring for a minimum of 3 months or until substantial compliance is achieved, a Quality Assurance tool has been developed and implemented to monitor the compliance of residents (resident representatives) making informed decision related to the covid vaccine. The tool reviews residents to assure that there is either a consent or a declination present. The tool will also monitor to assure that if the resident consented to the vaccine that it was administered. This tool will be completed by the DON, or designee, weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools **The date the systemic changes will be completed:** November 26, 2021	

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	Resident D was the first resident in the facility wide outbreak of 35 residents who tested positive for COVID-19 on 10/17/21. The, "Consent to Administer the Influenza Vaccination and the Pneumococcal Vaccination", form was signed by the Resident Representative on 8/11/21. There were no consent or declination forms signed for the COVID-19 vaccination in the record. A Nurse's Progress Note, dated 10/17/21 at 10:05 p.m., indicated an intermittent cough throughout the shift and the lung sounds clear and diminished. A Rapid COVID-19 test was performed with positive results. A Nurse's Progress Note, dated 10/24/21 at 7:50 a.m., indicated the oxygen saturation level was 80% on room air, 4 liters of oxygen re-applied and the the oxygen saturations increased to 87%. The temperature was 100.9. A Nurse's Progress Note, dated 10/24/21 at 8:35 a.m., indicated an order to transfer the resident to the Emergency Room. The resident returned to the facility on 10/24/21 at 4:50 p.m. A Physician's Progress Note, dated 10/26/21 at 11:35 p.m., indicated hypoxia when off of oxygen with oxygen saturations of 85% when oxygen was not being used. During an interview on 10/27/21 at 10:35 a.m., the Administrator indicated there was no declination or consent for the COVID-19			

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	Vaccination and they were working with the family today on this. During an interview on 10/27/21 at 10:55 a.m., the Director of Nursing (DON) indicated the COVID-19 Vaccine had not been offered and the Resident Representative was notified today and he would like the resident to receive the vaccination. The immediate jeopardy that began on 10/17/21 was removed on 10/29/21 when the facility had inserviced 6 of the 12 facility staff Nurses, the Social Service Director and 3 Agency Nurses, who had worked after the immediate jeopardy notification on 10/28/21, to offer the COVID-19, influenza and pneumococcal vaccine to all residents upon admission into the facility. The facility audited to ensure all other residents in the facility were offered the COVID-19 vaccination and vaccinated if consent was given. The noncompliance remained at the lower scope and severity level of actual harm that is not immediate jeopardy because the facility will need to inservice the other 6 Nurses and any Agency Nurse who may be scheduled and will need to audit all new admissions to ensure the COVID-19 vaccination is offered. This Federal tag relates to Complaints IN00365461 and IN00365465.			