STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING 00 B. WING	05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00353797 and IN00350692. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00353797 - Substantiated. Federal/State deficiency related to the allegations is cited at F600 Complaint IN00350692 - Substantiated, Federal/State deficiency related to the allegations is cited at F725. Unrelated deficiency cited Survey dates: May 18, 19, 20, 21, 22, 23, 24, and 25, 2021 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 9 Medicaid: 43 Other: 13 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

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

Any defiencystatement 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 disclo 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.

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	Quality review completed on June 4, 2021.			
F 0600 SS=J Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure effective interventions to prevent a delay in staff notification, action, assessment, and medical care for a resident having pain, shortness of breath, and numbness on the left side, resulting in the resident having no pulse, being unresponsive, and death. (Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 5/5/21 when a cognitively intact, male resident, notified the Dietary Manager, he was short of breath and had pain down his left side. The Dietary Manager notified two nursing staff. Neither nurse assessed the resident until he was found face down in the floor. The Health Facility Administrator and Acting Director of Nursing were notified of the Immediate Jeopardy on 5/20/21 at 1:27 p.m.	F 0600	**F 600- Free from Abuse and Neglect** Resident B no longer resides at the facility as Resident B expired. Residents who reside in the facility have the potential to be affected by this finding. A "30 day Look Back" audit of the progress notes was conducted facility-wide to identify any Changes of Condition, (per policy and regulation), experienced by any resident. These Changes of Condition were listed. The DON/Designee reviewed them to ensure that all were timely and accurately addressed per policy and regulation and that no neglect occurred. Any concerns would	06/25/2021

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	Findings include: A Progress Noted, dated 5/5/21 at 11:30 a.m., indicated Resident B had his light on around 10:00 a.m. The resident's vital Signs were obtained and include, but were not limited to, Blood Pressure 122/82; Pulse 80; Respirations 20; Oxygen Saturation 97.4 on room air and he voiced a complaint of pain in his right heel. The nurse was in the process of texting the doctor to notify him of the Norco needed when the DON (Director of Nursing) came to the desk and stated housekeeping had indicated the resident was on the floor. Upon entering the room, the resident was lying face down on floor beside bed. Resident B had been previously sitting in bed. Resident B was rolled over and assessed. No pulse or respirations noted. CPR immediately started by nurse and Hospice nurse who was on the hall. A Code (cardiopulmonary arrest) was started and 911 was called. CPR continued until EMS arrived and took over care. EMS called the resident's time of death at 10:49 a.m.. The clinical record for Resident B was reviewed on 5/18/21 at 10:15 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, heart failure, and COPD. A significant change MDS (Minimum Data Set) assessment, dated 4/1/21, indicated the resident was cognitively intact, he had adequate vision and hearing with clear speech, was able to understand and be understood. The resident required the extensive assistance of two physical staff members for mobility, transfer, and ADLs. He was always continent of bladder and bowel. A Care Plan, dated 3/19/20, indicated the resident had a diagnosis of CABG (aortocornary bypass).		have been addressed if found. Going forward, the daily morning CQI meeting agenda will continue to include a review of any Changes of Condition that have occurred since the previous daily morning CQI meeting to ensure that all protocols were followed per policy and procedure. The DON/Designee and the IDT will review these Changes of Condition. Any that occur on the weekend, will be reviewed during the following Monday's CQI meeting. The DON/Designee will monitor 5 Changes of Condition weekly x 4 weeks to ensure all protocols are followed timely and appropriately. Afterward, 3 Changes of Condition will be monitored weekly for a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. The Regional Nurse Consultant will monitor the Changes of Condition weekly x 3 months to ensure compliance is achieved. Any concerns will be addressed if found. Further, interviewable residents were interviewed to ensure that they feel like If they have a "need," or they have a request for a "service," (especially in an "emergent" situation), that need is met or that the requested service is performed timely and with a positive attitude. Any concerns	

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	The interventions included, but were not limited to, staff were to report any complaint of pain, respiratory changes, and weight increases to the doctor for evaluation and possible treatment. A Care Plan, dated 3/19/20, indicated the resident had a diagnosis of CHF (congestive heart failure). The interventions included, but were not limited to, staff were to observe the resident for shortness of breath. A Care Plan, dated 3/19/20, indicated the resident was at risk for a CVA (stroke). The interventions included, but were not limited to, staff were to observe the resident for signs and symptoms of chest pain, hypertension, shortness of breath, loss of vision, and unresponsiveness. Staff were to notify the doctor with symptoms. A Care Plan, dated 3/19/20, indicated the resident had a diagnosis of Coronary Artery Disease. The interventions included, but were not limited to, encourage the resident to alert staff upon onset of chest pain, shortness of breath, oxygen as ordered, and Pace care giving activities. A Care Plan, dated 6/11/19, indicated the resident had a Full Code Status. (all resuscitation procedures will be provided). The interventions included, but were not limited to, staff were to notify the doctor and family of any change in condition. During a telephone interview on 5/20/21 at 10:10 a.m., LPN 2 indicated she last observed the resident when he refused his medication, and she was not sure of the time, but she charted it. Later he was hollering so she went down, and he indicated he was in pain, but he no longer had Norco 10/325 and did not return from the hospital		were addressed. Additionally, staff were interviewed to ensure that they themselves need a response or input or assistance from another staff member, to address a resident's "need," or to perform "service" for a resident, (especially in an emergent situation), this happens timely and appropriately. Any concerns would have been addressed. The DON/Designee/SSD will monitor 10 residents weekly, to include those residents who are repetitive in their requests for assistance—to ensure those needs and services are being met and provided timely and appropriately, and that the culture of the staff is such that they, (residents), feel that they, (staff), desire to assist the residents with a positive approach and demeanor. Additionally, 10 staff members will be reviewed weekly to ensure that they get any needed assistance from other staff members to address any resident needs timely and appropriately. This monitoring will reduce to 5 residents weekly, (plus those residents who are repetitive in their request for staff assistance for a period of not less than 3 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. Any concerns will be addressed if found.	

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	with his original order for Norco 5/325. He was in bed with the head of the bed raised up. She could not recall the time and that she was not notified the resident was in distress. As far as she knew there was nothing out of the ordinary. She doesn't recall talking with staff at the nurses' station that morning. During an interview on 5/20/21 at 10:03 a.m., the DON indicated LPN 2 charted Resident B refused medications at 8:26 a.m. During an interview on 5/19/21 at 1:40 p.m., Housekeeper 5 indicated on 5/5/21 around 9:30 a.m., she had gone to Resident B's room and he told her to get him some help, that his entire left side was numb, and he was having pain. She went to the nurses station and notified CNA 7. CNA 7 indicated she would find and notify the nurse. Around 10:30 a.m. she was walking down the hallway, at the same time as the Agency CNA, and they saw Resident B face down on the floor. Housekeeper 5 ran down the hall hollering for the nurse. The DON, LPN 2, and CNA 6 responded. LPN 2 called for the crash cart, for staff to call 911, and initiated CPR until the Paramedics arrived and pronounced him dead. During an interview on 5/18/21 at 3:26 p.m., CNA 4 indicated on the morning of 5/5/21 she had answered Resident B's call light, he indicated he was sick and he wanted crackers. She returned with graham crackers and gave him a sputum tray since he indicated he didn't feel well. The CNA notified LPN 2 and the LPN said "ok." Later she heard hollering and Resident B was found on the floor with his arms at his side, palms up. "I don't recall the exact time; I'd rather not guess". During an interview on 5/18/21 at 3:00 p.m., the		Further Call Light response Audits and Change of Condition audits will be completed by the DON/Designee. These audits will be conducted on (Call Lights) 5 residents, 5 days weekly for 2 months. Then, for 5 residents, 3 days weekly for 2 months, then for 5 residents monthly for 2 months. The Change of Condition audits will be completed for every Change of Condition for 6 months. At an in-service to be held for all staff on June 23, 2021, conducted by the Director of Nursing, the following was reviewed: 1) Preventing Resident Abuse 2) Resident Rights 3) Resident Rights 4) Care Planning Process 5) Change of Condition 6) Charting and Documentation Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. The results of the monitoring by the DON/Designee/SSD related to staff response to the residents as well as staff respond to each other for assisting each other will be presented to the QAPI Committee at the monthly QAPI meetings. Also, the Call Light and Change of Condition audits results will be presented at the same time. Any concerns would have been	

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	Dietary Manager indicated she had checked on Resident B because he was calling for help most of the morning. When she entered the room at 10:10 a.m., Resident B was lying in bed, head of the bed was up, he had his hands up, and was gulping air, he indicated, "I can't breathe," gulped more air, and said, "get me some help." She notified the CNA 6 and the CNA said she was not going in due to he had cussed her earlier that day. LPN 2 was with another resident when she notified her and so she went to Morgan Hall and told LPN 3 at 10:15 a.m. During an interview on 5/18/21 at 2:40 p.m., LPN 3 indicated the Dietary Manager asked me to look at Resident B because he said he was dying or something. When he went to the nurses' station LPN 2 was talking to someone and said his vitals were good, no shortness of breath, and that he just liked to be babied. Later when LPN 2 was at the nurses station charting the DON came up and said to call 911 that Resident B was unresponsive. After the call, he went down, and they were doing CPR. During an interview on 5/19/21 at 1:35 p.m., LPN 3 indicated he did not actually speak to LPN 2 due to he assumed she was already aware based on the conversation she was having with another staff concerning Resident B's vitals, so he just returned to the Morgan Hall to finish passing his medications. During an interview on 5/21/21 at 10:12 a.m., LPN 3 indicated he had been the nurse on Morgan Hall. He had a cup of pills and a cup of water in his hand when he walked around the nurses station and down the Warrior Hall. LPN 2 was about half way down that hall. He didn't talk to her because she was telling another staff about		addressed as found. However, any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored weekly by the Administrator until resolved.	

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	Resident B, and he overheard her say his vitals are better than mine. During an interview on 5/20/21 at 9:40 a.m., the Acting DON indicated she was not in the building on 5/5/21. However, based on charting he was non-compliant with care, on dialysis, refused medications, and that was all she knew. During an interview on 5/20/21 at 9:52 a.m., the Administrator indicated 5/5/21 was her first day in the building and she was not out on the floor. She was not notified of Resident B's passing until after the fact. The current facility policy titled "Assessments," and dated August 2017, was provided by the Acting DON on 5/20/21 at 1:24 p.m. The Policy indicated, " ...ensure that assessments of the residents take place timely, ...Procedure: 1.) Assessments are completed using the "Required Nursing Clinical Assessments." ...when a significant change of condition occurs ...2.) Appropriate assessments can and will be completed at times based on the event ...D. Resident experiencing Pain ...Note: Nurses will perform appropriate assessments of the resident ...when a change in condition or circumstance takes place that requires "assessment" by qualified medical professional ..." The current facility policy titled "Change in Resident's Condition or Status," and not dated, was provided by the Acting DON on 5/20/21 at 1:24 p.m. The Policy indicated, "the resident's attending physician ...are notified of changes in the resident's condition or status ...Procedure: 1. The nurse will notify the resident's attending physician when: ...There is a significant change in the resident's physical ...status ..."			

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	The Immediate Jeopardy began on 5/5/21 was removed on 5/25/21 when the facility completed staff education on points of the in-servicing for change of condition, medical emergency, neglect, immediate notification and responding timely. Requirements for all staff to work together as needed to meet any resident needs or perform any services timely and appropriately were addressed. How to manage and work with residents who request staff assistance repetitively and effective care planning an monitoring. The Immediate Jeopardy was removed on 5/25/21, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy because not all staff had been educated on all change of condition points of in-servicing. This Federal tag relates to Complaint IN00353797. 3/1-27(a)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide			

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	services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review the facility failed to have adequate staff to provide showers for 5 of 8 residents reviewed for sufficient staffing. (Residents C, D, F, G, and H) Findings include: 1. The clinical record for Resident C was reviewed on 5/18/21 at 11:28 a.m. An Admission MDS (Minimum Data Set) assessment, dated 5/14/21, indicated the resident was cognitively intact, the resident had adequate hearing with clear speech, understands others and understood by others, vision highly impaired. The resident required the physical extensive assistance of one staff member for mobility, and required two physical staff extensive assistance for transfer and ADLs (Activities of Daily Living). He was occasionally incontinent of bladder and frequently incontinent of bowel. During an interview on 5/24/21 at 1:30 p.m., Resident C indicated he had not showered often while in the building. He appeared to be unkempt (not groomed). A Shower Schedule was provided by MDS	F 0725	**F 725- Sufficient Nursing Staff** Based on observation, interview, and record review the facility failed to have adequate staff to provide showers for 5 of 8 residents reviewed for sufficient staffing. (Residents C, D, F, G, and H). Corrective action has been accomplished for the alleged deficient practice regarding resident C, D, F, G, H, and staff members #1, #2, #3, #4, and #5. Residents C, D, F, and G have their needs met with adequate staffing. All residents have the potential to be affected. The Director of Nursing and/or his designee will be overseeing staffing development and assuring staffing is appropriate for the resident population. Additional staff has been hired and added to the daily schedule. In addition, the facility is participating in a CNA program that will be conducted at a sister facility. Once those staff	06/25/2021

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	Coordinator on 5/24/21 at 2:48 p.m. Resident C was to receive showers on Mondays and Fridays during the day shift. The Shower Sheets for the resident indicated he had received bed baths on 5/11/21, 5/15/21, and 5/18/21. The resident had not received a shower. 2. The clinical record was reviewed on 5/18/21 at 2:13 p.m. A Quarterly MDS assessment, dated 4/6/21, indicated the resident was moderately cognitively impaired, had adequate hearing and clear speech. The resident required extensive assistance of to physical staff for mobility, transfer, and ADLs. He was frequently incontinent of bladder and bowel. During an interview on 5/24/21 at 1:40 p.m., Resident D indicated he had a shower on 5/23/21. That was the first shower he had in about eight weeks. A man should not have to go beyond the point of having to smell himself and he would not let that happen again. On 5/21/21 at 10:49 a.m., the Business Office Manager (BOM) provided shower sheets for Resident D. The resident was to receive showers on Tuesdays and Fridays during the night shift. The Shower Sheets for the resident indicated he had a shower on 4/3/21, had refused a shower on 4/10/21, 4/20/21, 4/27/21, and 5/18/21. 3. The clinical record for Resident F was review on 5/24/21 at 11:44 a.m. A Quarterly MDS assessment, dated 2/19/21, indicated the resident was cognitively intact, he had adequate hearing, vision, clear speech, and was able to understand and be understood. He required two physical staff assistance for mobility, transfer, and ADLs. He was frequently incontinent of bladder and bowel.		members complete their training and pass their certification, they will be added to the daily schedules. A daily audit will be completed the day prior to any day worked to allow time to assure that the staffing is adequate to meet the needs of the residents based on their acuity and needs. The facility will assure adequate staffing through premium pay for interested staff who have not worked an excessive number of hours, sister facility staff, and agency staff. The resident's shower schedule has been evaluated for efficiency and effectiveness. The shower schedule will be based on the resident's room assignment unless there is a conflict with resident preference. The staff was educated on shower sheets, bathing schedules, and the importance of the resident being bathed. The education will be completed by 06/23/2021. A refusal of a shower must be documented by the assigned nurse. A second attempt by the following shift must be made. If the resident refuses a shower on the second attempt, the ADON or DON must be notified. Shower sheets are to be completed by staff with every shower and returned to the ADON for tracking. The Director of Nursing and/or his designee will complete auditing to assure the resident's shower	

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	On 5/21/21 at 10:49 a.m., the BOM provided shower sheets for Resident F. The resident was to receive showers on Mondays, Wednesdays, and Fridays during the day shift. The Shower Sheets for the resident indicated he had a shower on 4/2/21, 4/5/21, 4/11/21, 4/16/21, 4/19/21, 4/21/21, 4/23/21, 4/26/21, 4/30/21, 5/9/21, and 5/14/21. During an interview on 5/21/21 at 9:55 a.m., Resident F indicated he was supposed to get showers on Monday, Wednesday, and Friday. He had only gotten one shower a week for several weeks. The last shower he had received was on Monday this week and the week before. He would also like to lay down and rest between meals and smoke breaks but there were not enough staff to help him get up an he would miss his smoke breaks. 4. The clinical record for Resident G was reviewed on 5/24/21 at 3:27 p.m. A quarterly MDS assessment, dated 5/1/2, indicated the resident was cognitively intact, had adequate hearing and vision, clear speech, was understood and understands. He required one staff member's assistance with supervision for mobility and ADLs, he required supervision and set up help only for transfers. Always continent of bladder and occasionally incontinent of bowel. On 5/22/21 at 11:12 a.m., the DON provided shower sheets for Resident G. The resident was to receive showers on Mondays and Thursdays during the night shift. The Shower Sheets for the resident indicated he had refused a shower on 4/5/21, 4/15/21, 4/22/21,		schedule is being followed. The Director of Nursing and/or his designee will randomly review shower activity on 3 residents a day, five days a week, for 2 months. Next, 3 residents will be reviewed, 3 times a week, for 2 months. Lastly, 3 residents will be reviewed weekly for 2 months. Results from staffing audits and shower schedule audits will be reported at monthly QAPI meetings for review and revisions as necessary. Any concerns will be addressed, patterns will be identified, and if necessary, an Action Plan will be written by the QAPI committee. The Administrator is responsible for overall compliance of each part of this plan of correction	

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	4/29/21, 5/3/21, and 5/13/21. The resident had a shower on 5/10/21. During an interview on 5/22/21 at 11:05 a.m., Resident G indicated he had not had a shower for at least two weeks. He explained his showers were scheduled for nights and they do not wake him up for a shower, but just write refused on their papers. He would like to have a shower because no one wants to stink. He was observed to be unkept, he had dirty uncombed hair and a slight body odor. During an interview on 5/24/21 at 1:45 p.m., Resident G indicated he still had not had a shower, and wanted to know how bad he smelled. He was observed in his wheelchair in the hall. His appearance was unkempt, hair not combed, and a slight body odor. 5. The clinical record for Resident H was reviewed on 5/24/21 at 11:54 a.m. A Quarterly MDS assessment, dated 2/23/21, indicated the resident was moderately cognitively impaired, she had adequate hearing, vision, clear speech, and was able to understand and be understood. She required the physical extensive assistance of two staff for mobility, transfer and ADLs. She was always incontinent of bladder and frequently incontinent of bowel. On 5/21/21 at 10:49 a.m., the BOM provided shower sheets for Resident H. The resident was to receive showers on Tuesdays and Saturdays during the night shift. The Shower Sheets for the resident indicated she had a shower on 4/10/21; had a bed bath on 4/17/21; had a shower on 4/24/21, 5/1/21, and 5/12/21.			

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During an observation and interview on 5/22/21 at 10:45 a.m., Resident H was lying in bed. The call light was on the floor at the head of the bed. She indicated she was dirty and needed changed. The staff usually only washed her up with a bed bath.

During a confidential interview between 5/18/21 and 5/25/21, Staff 1 indicated there were not enough staff to meet the resident's needs. There was usually three nurses and three Certified Nursing Aides (CNAs) for the entire building, with one nurse and one CNA on the memory unit and two nurses and two CNAs for the main part of the building.

During a confidential interview between 5/18/21 and 5/25/21, Staff 2 indicated there was not enough staff to meet the needs of the residents. If there were call-ins, the building was short staffed, and it became difficult to get the two hour check and change done. Showers were nearly impossible, but staff tried to give a partial bath when able.

During a confidential interview between 5/18/21 and 5/25/21, Staff 3 indicated there was not enough staff to meet residents' needs. There are lots of staff leaving. On one particular day there were four Personal Care Aides (PCAs) and only one certified aide in the building. The PCAs had to be supervised to provide care. In the main building there are sometimes only two CNAs, so it is hard to get everyone changed. Staff could not always do showers, but was able to do partial baths. She indicated staff had stayed over on the night shift to help get people to bed due to there was only two CNAs on the night shift for the entire building. There were six people in one area who require two person assistance, and there was

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	one aide with one nurse on that hall. During a confidential interview between 5/18/21 and 5/25/21, Staff 4 indicated there was not enough staff and the ones here cannot meet all the resident's needs. She was supposed to give seven showers today, but had only given four full showers. She tried to wash the rest of them up. She was the only CNA on her hall. When she gave a shower that did not leave anyone on the hall to answer call lights. During a confidential interview between 5/18/21 and 5/25/21, Staff 5 indicated she had not even looked at showers today, because she was by herself, she had only given a couple of showers, but it was like that throughout the building. She could not give showers because there would not be anyone on the hall to answer lights. If a resident was a two person assistance, she would try to give them a bed bath. During a confidential interview between 5/18/21 and 5/25/21, Staff 6 indicated there was not enough nursing staff, the housekeepers had to pass meal trays, but were not given any training. There was not enough time to wash their hands every time, so as long as they did not touch anything other than the trays, they did not always perform hand hygiene. During a confidential interview between 5/18/21 and 5/25/21, Staff 7 indicated if there were three nurses and five CNAs in the building, they had no problem meeting the residents' needs. But if there are not that many, it was difficult to complete all the tasks. The current facility policy was provided by the Administrator on 5/18/21 at 10:10 a.m. The Policy			

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	indicated, " ...It is the policy of this facility to prevent ...neglect ...VII. Prevention ...on a regular basis, supervisors will monitor the ability of the staff to meet needs of residents ...For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: 8. Neglect/Mistreatment: means the failure to provide ...personal care or assistance with activities of daily living ..." This Federal tag relates to Complaint IN00350692. 3.1-17(a)			
F 0880 SS=E 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;			

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	§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; (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			

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	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 and interview, the facility failed to follow appropriate infection control guidelines related the use of personal protection equipment, hand hygiene, and the use of a gown and gloves in isolation rooms for 7 of 16 staff observed. (MDS Coordinator, CNA 14, Houskeeping Supervisor, CNA 15, CNA 12, Housekeeper 16, and LPN 13) Findings Include: 1. During an observation and interview on 5/18/21 at 12:53 p.m., The Minimum Data Set (MDS) Coordinator entered room 106 without putting on a gown or gloves. Observed a "Yellow" sign on the door which indicated contact precautions requiring a mask, gown, and gloves. During an interview the MDS Coordinator indicated she had entered room 106 without putting on a gown and gloves. During an interview on 5/18/21 at 12:55 p.m., Resident P indicated when staff brought in the meal tray they were wearing a mask but no gown or gloves. The resident in Room 106 was a newly admitted resident without being fully vaccinated. During an observation and interview on 5/18/21 at 12:53 p.m., The MDS Coordinator entered room 106 without putting on a gown or gloves. There was a "Yellow" sign on the door which indicated contact precautions requiring a mask, gown, and gloves. During an interview the MDS Coordinator indicated she had entered room 106 without	F 0880	**F 880 – Infection Prevention and Control** Currently, the MDS Coordinator, CNA #14, Housekeeping Supervisor, CNA #15, CNA #12 Housekeeper #16, and LPN #13 practice proper PPE usage as per Infection Control policies and regulations. All residents who reside in the facility have the potential to be affected by this finding. The Infection Preventionist/DON/Designee will make Infection Control Rounds 5 days weekly and will observe to see that any designated zones (Green, Yellow or Red), are maintained as per policy and procedure—driven by CDC guidelines and state and local mandates. Any concerns will be addressed if found. Further, the Infection Preventionist/DON/Designee will monitor 10 staff members 5 days weekly on various shifts to include some weekend days, to ensure proper use of all required PPE. Any concerns will be addressed if found. This monitoring will continue for 2 months. After that,	06/25/2021

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	putting on a gown and gloves. The resident wanted soft drinks from the pantry refrigerator and she should have had on a gown and gloves. 2. During an observation and interview on 5/18/21 at 1:50 p.m., Certified Nursing Assistant (CNA) 14 entered room 107 without putting on a gown or gloves. There was a "Yellow" sign on the door which indicated contact precautions requiring a mask, gown, and gloves. She indicated she should have put on a gown and gloves to enter the room. The resident in Room 107 was a newly admitted resident. 3. During an observation and interview on 5/19/21 at 2:20 p.m., the Housekeeping Supervisor entered room 111. There was a "Yellow" sign on the door which indicated contact precautions requiring a mask, gown, and gloves. The Housekeeping Supervisor indicated she did not put on a gown and gloves. The resident in Room 111 was a newly admitted resident. 4. During an observation and interview on 5/23/21 at 9:16 a.m., CNA 15 was standing at the nurses station with her mask under her chin. The CNA indicated the mask should be worn covering the nose and mouth. 5. During an observation and interview on 5/23/21 at 9:17 a.m., CNA 12 was at the nurses station with her mask under her nose. The CNA indicated the mask should be worn covering the nose and mouth. 6. During an observation and interview on 5/23/21 at 9:20 a.m., Housekeeper 16 was in the hall, in front of room 117, her mask was under her chin, and she was talking with the housekeeping supervisor. She indicated the mask should be		the Infection Preventionist/DON/ADON will monitor the designated zones, (Green, Yellow, Red), 2 days weekly to ensure the zones are maintained per policy and procedure---driven by CDC guidelines and state and local mandates. Any concerns will be addressed if found. Further, the Infection Preventionist/DON/Designee will monitor 5 staff members 2 days weekly on various shifts to include some weekend days, to ensure proper use of all required PPE. This monitoring will continue for 6 months to ensure ongoing compliance. Any concerns will be addressed if found. An all-staff in-service held June 23, 2021, conducted by the Director of Nursing. The following topics were reviewed: 1) PPE---proper use of masks/gloves/gowns/face shields/goggles 2) Covid-19 Zones---(Green/Yellow/Red)—review of the criteria for each zone 3) Required PPE for each “ZONE” 4) Hand Hygiene---requirements 5) Questions/Answers Any staff who fail to comply with	

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	worn over the mouth and nose and if touched you must hand sanitize. The Housekeeper pulled her mask up. No hand hygiene was observed. 7. During an observation and interview on 5/23/21 at 9:23 a.m., Licensed Practical Nurse (LPN) 13 was at the medication cart in the entrance to Warrior hall. She indicated she had been here since 6 p.m. the day before and was exhausted. She was in the process of preparing medication for Resident Q. She walked down the hall to room 107. Observed a "Yellow" sign on the door which indicated contact precautions requiring a mask, gown, and gloves. LPN 13 was observed at the bedside administering medication to Resident Q, she had on a mask and a pair of gloves. When done administering medication she went to the bathroom in the resident's room. Water was heard running, she then came out with a wet paper towel to clean the resident's face, stating he was wearing his breakfast. Upon exit she used hand sanitizer. She indicated in a yellow room staff are required to wear a gown, gloves, and a mask. She indicated she did not wear the gown. The current facility policy titled "COVID-19 PPE ZONES GUIDELINES," and dated 4/5/21, was provided by the DON on 5/23/21 at 12:15 p.m. The policy indicated, " ...B. YELLOW ZONE (Potentially/presumed positive ...) ...1. Gown, N95 mask, faces shield or goggles, gloves as usual ...7. All patients in the Yellow Zone should have a sing on their door indicating their zone and the proper PPE (Personal Protective Equipment) to be worn upon entering the room ..." The current facility policy titled "Donning and Doffing PPE Education," and not dated, was provided by the Administrator on 5/23/21 at 12:16 p.m. The policy indicated, " ...Donning PPE: 1.		the points of the in-service will be further educated and/or progressively disciplined as indicated. The results of the monitoring related to Infection Control will be presented to the QAPI committee at the monthly meetings. Any concerns will have been addressed. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plans will be monitored weekly by the Administrator until resolved.	

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	Hand hygiene. 2. Don Gown ...7. Don Gloves ..." 3.1-18(b)(2)			