DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 IN00369620, IN00369953, and IN00370020. This visit included a COVID-19 Focused Infection Control Survey. This visit resulted in a Partially Extended Survey - Immediate Jeopardy. Complaint IN00369620 - Substantiated. Federal/State deficiencies related to the allegation are cited at F689 and F880. Complaint IN00369953 - Unsubstantiated due to lack of evidence. Complaint IN00370020 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: January 5, 6, and 7, 2022. Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 1 Medicaid: 84 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 19, 2022.	F 0000	**Disclaimer:** **Envive of Indianapolis submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employee, agents, officers, or directors. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedures should be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis. This provider respectfully requests that the 2567 Plan of Correction be**	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			considered the Letter of Credible Allegation and requests paper compliance review in lieu of a Post Survey Review on or after January 28th 2022.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observations, interview, and record review, the facility failed to ensure a resident was transferred appropriately with a mechanical Hoyer lift to prevent the potential for accidents for 1 of 5 residents reviewed for accidents (Resident G). Findings include: During a continuous observation, on 1/7/22 from 11:40 a.m. until 11:55 a.m., the following was observed: At 11:40 a.m., Certified Nursing Assistant (CNA) 31 and CNA 32 were observed through Resident G's open door as they adjusted a Hoyer lift pad sling under the resident. At 11:41 a.m., CNA 32 exited the room (in full PPE) and retrieved the Hoyer lift from the hallway outside of the resident's room. At 11:44 a.m., CNAs 31 and 32 were observed as	F 0689	**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**. Any resident that requires Hoyer transfer can be affected. No further deficient practice could be identified during rounds. ="" p=""> **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of nursing/designee will educate all nursing staff on Hoyer transfers, and this will include return demonstration to ensure	01/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	they exited the room with Resident G suspended in the Hoyer lift sling. They pushed the Hoyer from the side of his bed, into the hall, and left him suspended in the Hoyer lift sling in the middle of the hall, as they returned to the bedroom doorframe to remove their PPE. At 11:47 a.m., CNA 32 walked around the resident, who was still suspended in the air, to the other side of the hallway and retrieved the resident's electric wheelchair from where it was plugged in. She maneuvered the wheelchair to the middle of the hall behind but not directly under the resident so that he was still suspended over the floor. Both CNAs left the resident's side and positioned themselves behind the electric wheelchair to adjust the wheelchair. Resident G remained suspended in the air greater than 3 feet off the ground without staff immediately at his side or with their hand on him at all times. At 11:52 a.m., CNA 31 returned to the front of the Hoyer lift controllers and pushed him closer to the wheelchair. CNA 32 kept position of the wheelchair while CNA 31 used the Hoyer controls to lower the resident into the seat of his wheelchair at 11:53 a.m. From the time the resident was backed out of his room as 11:41 a.m. until he was lowered into his wheelchair at 11:53 a.m., no staff member physically touched the resident or the Hoyer lift pad to guide and/or steady the resident throughout the transfer. During an interview on 1/7/22 at 11:48 a.m., the Vice President Regional Nurse indicated when staff completed a Hoyer lift transfer, a resident should not be left hung/suspended alone. Someone should always stay beside the resident to ensure the resident's safety. During an interview on 1/7/22 at 12:30 p.m.,		that same deficient practice does not occur again. Facility will implement Hoyer training during orientation process. DON/Designee will complete the audits Monday through Sunday on different shifts including weekends to ensure that residents are safe when transferred. DON/Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. ="" p=""> **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** sup=""> DON/Designee will complete random Hoyer transfer audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks. DON/Designee will complete the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Resident G was observed in his electric wheelchair in the hallway just outside of his room. He indicated he was a quadriplegic and required the use of a Hoyer lift for all transfers. Most of the time, only one CNA would come to help him get into the Hoyer pad sling, and then the CNA would call to have a second CNA come spot the lift. He indicated he had been left suspended in the Hoyer lift sling one time, with no staff supervision for over 15 minutes which had scared him greatly. Resident G indicated he was often left alone in the Hoyer lift sling for several minutes at a time. For example, if the Hoyer lift battery died, they would leave him to get a new one, or if they forgot supplies, or needed to go get his wheelchair. On 1/7/22 at 1:00 p.m., the Vice President Regional Nurse provided copies of Resident G's face sheet, diagnoses and care plan related to transfers and activities of daily living (ADL) requirements. Resident G had current diagnoses, which included, but were not limited to quadriplegia and muscle spasms. His Care Plan for ADL required assistance was dated 11/30/21 and indicated he required the total assistance of at least 2 staff for transfers. On 1/7/21 at 1:00 p.m., the Vice President Regional Nurse provided a copy of current facility policy titled, "Mechanical Lift," dated 10/2014. The policy indicated, "A mechanical lift enables nursing personnel to lift and transfer a resident to and from bed as safely and as easily as possible... two (2) personnel members must be present when a mechanical lift is utilized... The operator must use care and discretion with all lifts. Special care must be taken with persons who cannot cooperate while being lifted- such as comatose, spastic, agitated or otherwise severely handicapped persons ... mechanical lift unless specified		audits Monday through Sunday on different shifts including weekends to ensure that residents are safe when transferred then DON/Designee will bring the audit sheets back in morning meeting every day. The results of these audits will be reviewed in morning meeting. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Compliance-01/28/2022. sup="">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	otherwise, is for transfer only. It is not to be used for transporting or moving a resident from one location to another... Once confirmed sling is safely attached, proceed to pump handle until the resident's body clears the bed. NOTE: Make certain to support resident's head, neck, and feet... Roll the lift slowly away from bed and toward the chair. Have your assistant guide the resident's body gently until resident is directly over chair seat...." This Federal tag relates to Complaint IN00369620. 3.1-45(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse,			

except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

Based on observation, interview, and record review, the facility failed to ensure all medications were secure from unauthorized use when two medication carts for 36 of 37 residents residing on the unit and one treatment cart for 7 of 7 residents with medications in the treatment cart were left unlocked (Residents F, G, BP, BQ, BR, BS, BT, and BV).

Findings include:

1. On 1/5/22 at 12:21 a.m., Qualified Medical Assistant (QMA) 9 was observed leaving the B hall. She was wearing a surgical mask, then an N95 mask. The Front Med Cart and the Back Med Cart were observed to be unlocked. She was off the floor for several minutes.

On 1/5/22 at 12:44 a.m., QMA 9 indicated she left the B Back Medication Cart unlocked on purpose. She was leaving the B Hall and the D Hall Licensed Practical Nurse (LPN) needed to come and destroy Resident F's Tramadol (a controlled substance for pain). She was off the floor while the medication carts were unlocked and indicated the medication and treatment carts should have been locked at all times.

2. On 1/5/22 at 12:39 a.m., the treatment cart on the B hall was observed unlocked. A few of the prescription medications inside were:
a. Resident G's ketoconazole (topical antifungal) and two tube of bacitracin (topical antibiotic).
b. Resident BP's diclofenac (anti-inflammatory).
c. Resident BQ's capsaicin cream (used to treat pain).

F 0761

01/28/2022

POC- 761

what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?
All the nursing staff will be educated and in serviced to ensure all medications carts that store all drugs and biologicals are in locked all the time when not in use.

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;
Director of nursing/designee will audit all the carts in the building to ensure that the carts are locked all the time. If carts are found open the staff member responsible for the cart will be immediately educated to ensure that deficit practice does not reoccur.

/p>

- **what measures will be put into place and what systemic**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	d. Resident BR's hemorrhoidal cream (used to control symptoms of hemorrhoids). e. Resident BS's honey gel (used to treat wounds). f. Resident BT's hydrocortisone cream (used to treat the discomfort of skin conditions). g. Resident BV's lidocaine/prilocaine cream (used numb the skin). During an interview, on 1/7/22 at 11:15 a.m., the Administrator indicated the medication carts and treatment cart should have been locked at all times, unless they are in line of sight of the staff responsible for them. During an interview, on 1/7/22 at 1:25 p.m., the Regional Clinical Support indicated it is the expectation of the staff to always lock the medication carts. A current policy, titled, "PCU018-Medication Administration and General Guidelines," dated 2020, was provided by the Interim Director, on 1/7/22 at 9:05 a.m. A review of the policy, indicated, " ...leaving the cart locked and secured ...." 3.1-25(m)		**changes will be made to ensure that the deficient practice does not recur.** Director of nursing or designee will be randomly making rounds on the different hall different days making sure the medication/treatment carts are locked all the time. Any concerns will be immediately addressed, and staff will be immediately educated.DON/Designee will complete the audits Monday through Sunday on different shifts including weekends to ensure that carts ae locked all time. DON/Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. /p> - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			/sup> DON/Designee will complete random audits daily Monday through Sunday four times a week on random shifts including weekends for four weeks, then three times a week for two weeks, then two times a week for the two weeks, once a week for one weeks. DON/Designee will complete the audits Monday through Sunday on different shifts including weekends to ensure that carts ae locked all time. DON/Designee will bring the audit sheets back in morning meeting every day to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Compliance-01/28/2022. /sup> sup="">	
F 0880 SS=K 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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; (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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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, interview, and record review, the facility failed to ensure infection control practices for COVID-19 were implemented to prevent and contain the spread of the COVID-19 virus which resulted in immediate jeopardy when the facility failed to ensure Transmission Based Precautions (TBP) were implemented for residents after positive antigen tests and/or exposure to positive residents, to ensure TBP isolation signage and Personal Protective Equipment (PPE) were readily available, to ensure staff were informed of newly identified antigen positive residents, and staff wore appropriate PPE while providing care for residents	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Facility immediately placed Resident BC and BB in TBP (Transmission based precautions)- · BD was immediately moved to TBP · RN 22 was immediately educated about proper use of PPE in TBP	01/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	who were presumed COVID-19 positive after exhibiting signs/symptoms of the virus. The immediate jeopardy began on 1/4/22 when the facility failed to immediately isolate and place two residents, (Residents BC and BB) in TBP after they became symptomatic and had a COVID-19 positive antigen test. Resident BC's roommate (Resident BD) was not moved to another room or placed on TBP isolation after his exposure to BC, putting him at imminent risk of infection. Resident BC received a visit from a hospice nurse, Registered Nurse (RN) 22. She entered his room without proper PPE and provided resident care. RN 22 then moved to another resident's room, (Resident BF) who was also a hospice resident that tested positive for COVID-19 and was observed in the room without appropriate PPE in place. Resident BB's roommate, (Resident L) was not placed on TBP isolation after his exposure and was observed on multiple occasions as he independently ambulated throughout the entire B hall, into the main front entrance lobby without staff redirecting back to his room or encouragement to wear appropriate PPE, and Resident L was observed sleeping in other residents' rooms who had tested negative (Residents J and B) putting them both at imminent risk of infection. Multiple observations of staff revealed inappropriate use of a N95 respirators, inappropriate donning of and/or lack of donning required PPE before entrance into TBP isolation rooms, inappropriate hand hygiene, and lack of awareness of the COVID-19 status of each resident on the hall where the outbreak occurred. These deficient practices put 3 of 37 residents (Residents BD, J, and B) at immediate risk of infection by direct exposure of positive/symptomatic residents during a facility outbreak. Further, these deficient practices had		· Resident L was immediately placed in TBP and was encouraged to not to go out of his room without appropriate PPE (mask) · Staff was immediately educated to encourage Resident L to stay in his room, and if he leaves, he needs to wear a mask. · Multiple staff were immediately educated on appropriate use of a N95 respirators, required PPE before entrance into TBP isolation rooms, and appropriate hand hygiene. · Resident BB was immediately transferred to a different room. · QMA 9 was immediately educated about proper use of PPE in all zones · CNA 10, 11,13, 16, 20, were educated not to use surgical mask below the N95 masks and were educated about proper use of PPE · All the isolation signage, or personal protection equipment (PPE) information was posted on the resident doors immediately. · LPN 12 was educated to immediately complete all the PCR tests if resident needs it at that time regardless of if resident is sleeping or not. · CNA 13 was immediately educated and informed about all residents and there COVID status and was also educated how to handle Linens out of a resident room and proper use of PPE.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the potential to effect 37 of 84 residents residing on the B hall where the outbreak occurred. The Administrator, the Interim Administrator, the Regional Clinical Support Nurse, and Director of Nursing Services were notified of the Immediate Jeopardy at 6:25 p.m. on 1/5/22. The immediate jeopardy was removed on 1/6/22, but noncompliance remained at a lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:1. During an interview, on 1/5/22 at 12:16 a.m., the Director of Nursing Services (DNS) indicated the facility had 10 positive COVID-19 cases based on Point of Care (POC: rapid Covid result testing) determined earlier that day. The DNS indicated the facility was not going to move the residents into the red zone (COVID-19 positive isolation unit) until they received confirmation by PCR (lab testing) results back which could take up to 48 to 72 hours. This determination was made due to the fact POC tests often gave "false positive" results. On 1/5/22 at 12:58 a.m., Resident J and Resident L were observed sleeping in the same room. They were not wearing masks. Resident J was asleep in her bed, and Resident L was asleep in his wheelchair, within 6 feet of her bed. At this time, no staff was observed to redirect Resident L out of the room. On 1/5/22 at 1:42 a.m., Resident L was observed. He remained asleep in Resident J's room. At this time, no staff was observed to redirect Resident L out of the room. During an interview, on 1/5/22 at 11:24 a.m., Resident L indicated his roommate, Resident BB,		· Housekeeper 18, CNA 16, CNA 20, CNA 14, QMA 29, Therapy Director, Housekeeper 36, CNA 35, CNA 16, were all educated about the use of proper PPE · QMA 29 was immediately educated on proper doffing and discarding PPE and hand hygiene · CNA 19 was immediately educated on how to appropriately carry clean linens · LPN 12, LPN 8 was immediately educated on proper PPE while completing POC test · RN 22 was provided in-service where to get the bins if needed on the unit. · CNA 32 was educated on proper use of PPE and hand hygiene for all zones · Interim Administrator, receptionist and owner were immediately educated on proper PPE for Yellow zones · All staff was educated where back up PPE was stored so Isolation carts could be stocked as needed. · Housekeeping staff are educated on proper cleaning of resident rooms and proper placement and storage of housekeeping carts · A root cause Analysis with the consultant Dawn Nordoff was conducted which provides in the person visit with input from the facility medical director/DON. · Root cause Analysis was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	tested positive for COVID-19 the day before around noon. The facility staff had not moved his roommate out of the room, and Resident L indicated that was why he went to Resident J's room most of the night. He also later went to Resident B's room and slept for about an hour. Resident L indicated he refused to sleep in the room with his roommate (Resident BB) because Resident BB was COVID-19 positive. On 1/5/22 at 12:52 p.m., Resident L was observed in commons room watching T.V., without re-direction from passing staff. During an interview, on 1/5/22 at 1:30 p.m., Resident L indicated staff told him he needed to go sleep in Resident B's room. Resident L and Resident B both tested negative for COVID-19 on 1/4/22. Resident L indicated the bed in Resident B's room was an old crank bed and he could not operate it to get in and out of bed because of issues with his right leg. Resident L indicated he had received 2 shots of the COVID-19 vaccine. 2. On 1/5/22 at 12:57 a.m., QMA 9 was observed as she entered Resident BB's room after he tested positive and exhibited symptoms and began to assess him by taking his vital signs. She put gloves on but did not don an isolation gown or perform hand hygiene before she entered his room. She indicated Resident BB's oxygen saturation was 89 percent (%). She then continued on her assignment and made contact with additional unidentified residents. On 1/5/22 at 1:18 a.m., a brief review of Resident BB's paper chart was completed. His COVID-19 vaccination card was observed in his chart, it showed he was vaccinated with Moderna.		lack of the education for all staff including housekeeping, nursing staff. · It was identified that staff failed to utilize the PPE appropriately/Doff appropriately/Discard contaminated Appropriately. · This practice was identified in multiple areas within the facility at different times and different shifts. · There were multiple staff members who were identified as not following the proper protocol. So these staff members had been Inservice on infection control protocol. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**. 100% of residents had the protentional to be affected. All residents were tested immediately and placed in the appropriate areas based on test results/exposure. Residents were educated/encouraged to stay in their rooms. Residents were educated/encouraged to were mask when out of room. Appropriate signage was placed in Transmission Based Precaution areas for all to see. All Staff involved have watched the PPE Usage	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 1/5/22, a Surveillance Line List, provided by the facility, dated 1/4/22, indicated Resident BB was symptomatic with fever, cough, and myalgia (muscle pain). On 1/5/22 at 4:15 p.m., the Administrator indicated Resident BB's vital signs at 1:45 p.m. were blood pressure 128/70, temperature 101.4 Fahrenheit (F), pulse 90, respirations 20. On 1/5/22 at 6:21 p.m., Regional Clinical Support provided Resident BB's documentation of his positive COVID-19 test on 1/4/22. 3. On 1/5/22 at 12:21 a.m., Qualified Medication Aide (QMA) 9 was observed at the B hall nurse's station desk. She wore a surgical mask under her N95 mask, which prevented a tight seal of the N95. On 1/5/22 at 12:22 a.m., Certified Nursing Aide (CNA) 10 and 11 were both observed on the B hall. They wore a surgical masks under their N95 masks, which prevented a tight seal of the N95. They both indicated they were working from 7:00 p.m. to 7:00 a.m. During an interview, on 1/5/22 at 12:32 a.m., CNA 10 indicated she thought there were 4 rooms on the B hall who had positive residents but was unaware of any other resident's COVID-19 status. On 1/5/22 at 12:34 a.m. no isolation signage, or personal protection equipment (PPE) information was observed to be posted on any resident doors. On 1/5/22 at 1:34 a.m., Licensed Practical Nurse (LPN) 12 indicated she had not completed all the PCR tests, she still had 5 residents left, but did not want to wake them. She would complete their testing later that morning during morning		Video-http://youtu.be/YYTATw9ya v4 and have received education on the facilities policies and procedures for transmission-based precautions. All Staff involved have completed a posttest and was required to return demonstration on proper donning and doffing of mask, respirator devices (N95), gloves, gown, and eye protections. All Staff involved have been educated on Hand Hygiene (hand washing and ABHS), completed posttest, and was required to return demonstration. All staff members were educated on infection prevention/control program, which included PPE with don/doffing, hand hygiene, and COVID outbreak/testing. All staff were educated on location of back up PPE, linen handling, and communication/notification of COVID with in the building. Administrator has been educated on how to notify staff when COVID is identified within the facility. Housekeeping will receive education on proper storage of housekeeping carts at all times. /p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

medication administration.

On 1/5/22 at 1:37 a.m., the Interim Administrator was observed in the B hall. She wore an N95 respirator, but the bottom strap hung lose under her chin so that a seal was not created. She did not have on eye protection. She indicated the facility had 10 positive POC test results on 1/4/22, 6 residents on B hall, 3 residents on C hall, and 1 resident on D hall, so the entire building was considered "Yellow" (unknown COVID-19 status) and on TBP.

On 1/5/22 at 11:34 a.m., CNA 13 indicated she heard from other staff that only Resident Y was COVID-19 positive on the B hall and was unaware of the COVID-19 status of any other residents, or the need to follow TBP precautions.

On 1/5/22 at 3:56 p.m., LPN 21 indicated Resident C and Resident BH shared one room. Resident C tested positive for COVID-19 on 1/4/22 but had not been moved to the COVID-19 unit until the afternoon of 1/5/22.

On 1/5/21 at 11:00 a.m., the Receptionist and the Interim Administrator were observed wearing N95 masks but no face shields near the reception desk.

On 1/5/22 at 11:34 a.m., CNA 13 was observed exiting Resident D's room after changing her bed linens, she dragged the bag of soiled linen on the carpet to the soiled linen closet. She was still wearing her soiled gown and gloves. She removed the gown and gloves in soiled linen closet near B hall nurse's station. She was wearing a surgical mask under her N95 mask. The lower strap of N95 was hanging below her chin. She indicated she heard from other staff that only Resident Y was Covid positive on the B hall.

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.

After consultation with infection Preventionist the following systematic changes will be implemented. During this consultation LTC infection control assessment was updated.

DON/Designee will provide monthly in-services that will vary from appropriate PPE, Hand Hygiene, COVID outbreaks/testing and infection Control.
DON/Designee will provide ongoing education when items surrounding appropriate PPE that includes don/doffing, Hand Hygiene, COVID outbreaks and infection prevention/control are identified with in the facility.
/p>
sup

/p>

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and

DON/Designee will complete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 1/5/22 at 1:25 p.m., CNA 16 was observed assisting Resident G in his room with eating. She was not wearing a gown or gloves. She indicated she did not see the yellow zone signs on the front door of the facility when she entered the building. On 1/5/22 at 3:50 p.m., Housekeeper 18 was observed as he worked on the B hall. He wore a N95 mask with his nose outside the mask. He did not don and doff an isolation gown or gloves or perform hand hygiene before he entered several residents' rooms on the B hall where the outbreak occurred. He briefly entered 9 rooms on the B hall. Both straps of his N95 mask were below his ears. On 1/5/22 at 4:05 p.m., the Administrator indicated, Staff member 18 should have received infection control education before he worked on the floor as a housekeeper. Staff member 18 was only supposed to have vacuumed the B hallway, and not have entered resident rooms. On 1/5/22 at 4:11 p.m., Housekeeper 18 indicated he did not feel "good" and had a runny nose. He did not report it to his supervisor. On 1/7/22 at 9:13 a.m., Qualified Medication Aide (QMA) 29 was observed as she left Resident BL's yellow zone room. She was still wearing her soiled gown and gloves. She removed them in the hallway, just outside the room. She rolled up the soiled gown and placed it in the medication cart trash can. On 1/7/22 at 9:21 a.m., QMA 29 was observed as she left Resident BM's yellow zone room, she closed the door behind her. She was still wearing her soiled gown and gloves. She removed them in the hallway. She rolled up the soiled gown and		random audits/walking rounds for infection control daily Monday through Sunday on multiple shifts for 3 consecutive months, then three times a week for four weeks, then two times a week for the four weeks, once a week for four weeks. DON/Designee will bring the audit sheets into morning meeting Mon- Fri to be reviewed. The results of these audits will be reviewed in Quality Assurance meeting monthly for a minimum of 6 months and until 100%complaince is achieved for 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated F880 Infection Control Shift D/N App signs/Iso carts present and Stocked (Y/N) PPE being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	placed it in the medication cart trash can. On 1/7/22 at 9:36 a.m., QMA 29 was observed as she left Resident K's yellow zone room and walked up to the medication cart. She was still wearing her soiled gown and gloves. She placed the albuterol (bronchodilator to ease breathing) on top of the medication cart, threw the medication cups away, then removed her soiled gown and gloves. She rolled up the soiled gown and placed it in the medication cart trash can. 4. On 1/5/22 at 4:35 p.m., CNA 19 was observed carrying linens against her body. She indicated she was going to change linens in Resident J's room. On 1/7/22 11:18 a.m., the Regional Clinical Support indicate staff should have been carrying bags of soiled linens and not dragging them on the floor. If the linen bags were too heavy, they should have gotten a cart. Staff should have doffed soiled PPE before exiting any resident rooms because trash cans were available in the resident room. Clean linens should be carried away from the body. During an interview, on 1/7/22 at 9:46 a.m., the Regional Clinical Support indicated the facility did not have a policy on handling linen. She added, "There is the standard of practice that clean linens are carried away from the body, dirty linens are put into a bag. The bag shouldn't be dragged on the ground ...." 5. During an interview on 1/5/22 at 11:28 a.m., LPN 21 indicated Residents BC, Y, and BB all tested positive for COVID-19 on 1/4/22. At that time, none of the COVID-19 positive residents had been moved to the red zone (a separate isolation area for COVID-19 positive residents), 2 of the 3 residents still had roommates in the		worn/don doffed Appropriately (Y/N) Housekeeping carts are stored appropriately (Y/N) Linens are handled appropriately Y//N) Any action needed Y/N) What action was done	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	rooms, and no signs were placed on their doors to indicate the residents had COVID-19 and what PPE (personal protective equipment) staff should put on before they entered the residents' room. At that time, Resident BC was observed from the hallway, through the open door to his room. He was seated in a chair that was placed between his bed and his roommate's bed. His roommate, Resident BB, was observed lying in his bed next to the seated Resident BC. There was no sign on the room door to indicate the resident was on transmission-based precautions (TBP). During an interview on 1/5/22 at 11:37 a.m., LPN 21 indicated, she was the nurse who performed COVID-19 testing on the B wing residents on 1/4/22. She saw the positive results for Residents BC, Y, and BB. LPN 21 indicated the residents who tested positive on 1/4/22 were still in their rooms and had not been moved to isolation at that time. On 1/5/22 at 1:39 p.m., Residents BC and BB were observed in their rooms. Resident BB was observed seated in a chair that was placed between his bed and his roommate's bed. His roommate, Resident BD, was observed lying in his bed next to the seated Resident BC. During an interview at that time, the Therapy Director indicated he could identify both residents. He observed the residents in their room, from the hallway, through the residents' open door, and confirmed the identity of Residents BC and BD. The Therapy Director confirmed the residents were still in the room together. On 1/5/22 at 1:40 p.m., Residents BC and BD were observed with the Interim Administrator present. She confirmed Resident BC had tested positive for COVID-19 and his roommate, Resident BB had		Name of person completing audit ________________________________ ___	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	tested negative. The Interim Administrator indicated Resident BC should have been moved out of the room, and transferred to the Red Zone to not further expose Resident BD. During an interview on 1/5/22 at 3:49 p.m., LPN 21 indicated she was familiar with Resident BC and had cared for him before. He had been able to feed himself, help with his own care, and hold conversation. However, when she took care of him on 1/3/22 he was weak, and he had no appetite. His speech was not as clear as usual, and he was complained of not feeling well. LPN 21 indicated she felt like the resident just was not right and was not his usual self. LPN 21 indicated no COVID-19 test was performed at that time. On 1/5/22 at 6:21 p.m., the Regional Clinical Support RN (Registered Nurse) provided a document that indicated on 1/4/22, Resident BC tested positive for COVID-19, and Resident BD tested negative. 6. On 1/5/22 at 11:30 a.m., RN 22 was observed as she exited Resident BC's and BD's room. She wore a KN95 face mask and goggles. During an interview at that time, RN 22 indicated, she was a visiting hospice nurse. She had just completed resident care and nursing assessment which included a set of vital sings for Resident BC. She had been in his room for approximately 10-15 minutes. She wore a KN95 mask, goggles, and gloves while she provided care for the resident. She had not put on an isolation gown. RN 22 indicated she was not aware the COVID-19 status of the residents and had not been informed if any residents in the facility had tested positive for COVID-19. On 1/5/22 at 11:38 a.m., RN 22 was observed from		Date audit completed ________________________________ _______ /sup> /sup> /sup>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

the hallway, through an open door, in the room of Resident BF. RN 22 wore a KN95 mask, goggles, and an isolation gown that was untied in the back and hung lose and open. She did not have gloves on. RN 22 indicated, she still had not been told if there were COVID-19 positive residents on that hall. There were no signs on Resident BF's door to indicate she was in TBP or had tested positive for COVID-19. Resident BF was observed and still in her room at that time.

On 1/5/22 at 1:42 p.m., the Administrator confirmed Resident BF was still in her room. There were no signs on Resident BF's door to indicate she was in TBP or had tested positive for COVID-19.

On 1/5/22 at 6:21 p.m., the Regional Clinical Support RN provided a document that indicated on 1/4/22, Resident BF tested positive for COVID-19.

7. On 1/4/22 at 11:55 p.m., the main entry doors to the facility were observed. Signs on the doors indicated, "Yellow Zone Transmission Based Precautions Contact Droplet. PPE required: N95 mask, universal eye protection: faceshield or goggles must cover the top, bottom and sides of the eyes with no gaps (*For all HCP [health care personnel] regardless of vaccination status), Single gown - with each encounter, Gowns must be single use per resident. If crisis capacity- follow this rule one gown per each staff member, per each resident, per shift; gloves (hand hygiene donning/ doffing)."

On 1/5/22 at 11:14 a.m., CNA 13 (certified nursing assistant) was observed as she changed the bed linens in Resident D's room. CNA 13 was observed wearing 2 surgical masks under an N95

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	mask. The bottom strap of the N95 mask was not secured behind her head and it hung loosely at her chin. During an interview on 1/5/22 at 11:16 a.m., CNA 13 indicated she wore 2 surgical masks under her N95 mask and did not secure the bottom strap of the N95 mask, because it was uncomfortable. The N95 mask was worn to protect the staff and the resident. The N95 mask protected against COVID-19 more than the surgical mask. CNA 13 indicated she had been taught how to properly wear the N95 mask, she knew it should be a tight seal against her face, and she should use both straps to secure the mask onto her face, but it was uncomfortable that way. On 1/5/22 at 11:21 a.m., CNA 20 was observed walking through the B wing hall. She wore a surgical mask with an N95 mask on top of it. The bottom strap of the N95 mask hung loosely at CNA 20's chin. CNA 20 also wore a disposable gown, that was untied in the back and hung loosely off her shoulders, a face shield, and gloves. She was observed as she carried linens into Resident B's room and closed the door behind her. On 1/5/22 at 1:25 p.m., CNA 16 was observed seated directly next to the bed of Resident G. CNA 16 was observed as she hand-fed pizza to the resident. CNA 16 wore an N95 mask and a face shield. She did not have on a gown or gloves. At that time, the ED was observed as he asked CNA 16 why she did not have on a gown and gloves while she was in the resident's room providing care. CNA 16 indicated she did not have on full PPE because the resident did not have COVID-19. The ED indicated the entire facility was a yellow zone due to COVID-19 positive residents and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	staff. On 1/5/22 at 3:46 p.m., CNA 13 was observed changing the bed linens in Resident G's room. She wore 2 surgical masks, covered by an N95 mask. The bottom strap of the N95 mask was not secured and hung loosely at her chin. She also wore a face shield and gloves. She did not have on a gown as she changed the resident's bed linens. On 1/5/22 at 6:30 p.m., CNA 13 was observed in Resident BK's room providing care. CNA 13 had on 2 surgical masks, covered by an N95 mask. The bottom strap of the N95 mask was not secured and hung loosely at her chin. She also wore a face shield, gloves, and a gown that was untied in the back. During an interview on 1/5/22 at 10:25 a.m., the Interim Administrator, Director of Nursing Services (DNS) indicated they had just started work at the facility on Monday 1/3/22 and were still in the process of determining the full extent of the COVID-19 status of the building and facility-specific infection control procedures. So far 10 residents had tested positive for COVID-19 on rapid POC tests, and to their knowledge had all been moved to the Red Zone which was located on the A hall. The Interim Administrator indicated in her previous experience at other facilities with outbreaks, any resident who tested positive regardless of POC or PCR test would be moved to the Red Zone, and any resident who had contact with those positive residents would be placed on TBP and monitored closely for the development of signs/symptoms. During an interview on 1/5/22 at 11:15 a.m., RN 21 indicated she knew there were several COVID-19			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

positive residents still in their rooms on the B hall because she tested them the night before and has provided care to them that morning. She indicated there were only 2 PPE bins on the hall at that time, and no signs about COVID status were posted on any resident doors.

On 1/5/22 at 11:16 a.m., CNA 20 was observed as she wore only a surgical mask and face shield. She indicated no one told her that any resident on the B hall was positive, and she had not been putting on isolation gowns or gloves before she provided care to any of the residents.

During an interview on 1/5/22 at 12:55 p.m., the Administrator (ADM), the Interim Administrator, the DNS, and the Regional Clinical Support were present. The Interim Administrator and DNS were brand new to the facility and their first day was Monday, 1/3/22. Upon their first visit and tour of the building, Licensed Practical Nurse (LPN) 24 notified the DON, Resident Z was not feeling well and acted "off." The DNS personally assessed him at that time and indicated he looked weak. Staff added oxygen (02) via a nasal canula (NC) and got his 02 saturations up to 86%. His blood pressure (BP) was 82/51, so they called for an order to send him to the emergency department and Resident Z was discharged to the hospital. The following day, the Admissions Director went to visit Resident Z at the hospital but was informed he had tested positive for COVID-19, so she called the facility to let them know. At that time, on 1/4/22 around 3:30-4:00 p.m., the facility began POC antigen testing for every resident. During the initial round of tests, more resident began to test positive and by 6:00 p.m. a total of 10 residents had positive POC tests. Additionally, earlier that day, on 1/4/22, staff notified the DNS, Certified Nursing Assistant (CNA) 14 was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	feeling well. The DNS observed CNA 14 in a resident's room (on the B hall where the outbreak occurred) with two other staff (CNA 15 and RN 25). CNA 14 was sitting in a chair without an isolation gown on, as she had removed it because she was so sweaty. The DON immediately removed CNA 14 from the room, gave her a POC test which was positive, and she was sent home. CNA 15 and RN 25 were given POC tests and were determined to be negative, so they were allowed to finish their shifts. Dietary Aid (DA) 26 reported he did not feel well, and also tested positive on a POC test. He was sent home. The Interim Administrator and DNS did not know if the rest of the dietary/kitchen staff had been POC tested after their contact with DA 26. Only that the Dietary Manager (DM) had recently had COVID-19 and was within her 90-day grace period of immunity, therefore would not have required testing. At this time the Administrator, the Interim Administrator, the DNS, and the Regional Clinical Support were notified that 6 residents who tested positive were still in their rooms. Resident BC who was positive and symptomatic, still had a roommate and had received a visit from a hospice nurse who had not donned appropriate PPE, staff were not donning appropriate PPE before entering resident rooms, and Resident , who had been exposed by his symptomatic and positive roommate, Resident BB, had been observed in other resident rooms, and throughout the building. There were no COVID-19 status Red/Yellow stop-signs observed on any resident doors, and that several staff did not know the COVID-19 status of the building and therefore were unaware they needed to follow TBP precautions. The Administrator indicated any positive resident should be moved to the Red Zone, and signs should be posted immediately. The Scheduler who also helped complete POC			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

testing, should have sent a text message to all employees to inform them that residents were positive and to take TBP precautions.

8. On 1/5/22 at 12:32 a.m., LPN 12 was observed on the C hall as she pushed a rolling cart with COVID-19 rapid/antigen tests. She had on a surgical mask and face shield. She indicated she was testing residents on the C wing due to the current COVID-19 outbreak in the facility. In order to complete the tests from one resident to the next, LPN 12 indicated she had not worn an N95 face mask, nor had she donned an isolation gown before testing.

On 1/5/22 at 12:39 a.m., LPN 8 was observed on the D hall. She wore a surgical mask and a face shield. At this time, LPN 8 indicated she assisted in the COVID-19 outbreak testing of residents on the D hall but had not worn an N95 face mask or isolation gowns when she tested the residents.

On 1/5/22 at 11:20 a.m., the Therapy Director and another therapy staff were observed in a resident room on the B hall where the COVID-19 outbreak occurred. Both staff wore a surgical mask and face shield. The Therapy Director indicated they were about to get the resident up an into her wheelchair. The Therapy Director indicated he was aware the whole building was on Yellow TBP precautions, but indicated he only needed to don full PPE if he provided direct resident ADL care.

On 1/5/22 at 11:30a- Housekeeper 36 was observed at the D hall nurses' station. He wore an N95 face mask, but the bottom strap was not in place, and hung lose below his chin so that a seal was not created.

On 1/5/22 at 11:34 a.m., A resident was observed

on the D hall through her open door. She had removed her pants and briefs. At this time, CNA 35 entered her room without performing hand hygiene. He wore only an N95 and face shield but did not don an isolation gown or gloves.

On 1/5/22 at 1:25 p.m., CNA 16 was observed in Resident G's room as she assisted him with a meal. She wore an N95 face mask and face shield, but did not have on an isolation gown, or gloves. At this time, the ADM observed CNA 16 and asked why she was not wearing full PPE as the whole building was in outbreak and TBP precautions. CNA 16 indicated, "because he doesn't have COVID."

On 1/5/22 at 1:28 p.m., the Facilities Owner was observed in a resident commons area and wore only a surgical mask and face shield. He rummaged through a supply box as Resident L, (a resident with direct, prolonged exposure to his COVID positive roommate) slowly wheeled past him.

On 1/5/22 at 1:50 p.m., the facilities Owner was observed in the front lobby wearing a surgical mask with a face shield and had not put on an N95.

On 1/5/22 at 3:43 p.m., CNA 13 was observed. A surgical mask was observed under her N95 so that a proper seal was not created. Resident G was observed in the hallway as he spoke with CNA 13 who did not redirect him back to his room or encourage him to put a mask on.

On 1/5/22 at 3:54 p.m., the facilities Owner wore a surgical mask with a face shield. He had not put on an N95.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	During a continuous observation on 1/7/22 from 10:34 a.m. until 10:40 a.m., the following was observed: At 10:34 a.m., CNA 32 knocked on the kitchen door and requested cereal, milk, and coffee for two residents. At 10:37 a.m., the Kitchen Manager handed CNA 32 a tray with three individual milk cartons, three covered plastic bowels (not disposable Styrofoam) and a cup of coffee. At 10:38 a.m., CNA 32 walked onto the B hall (where the COVID-19 outbreak occurred) and entered the room of unidentified resident with the tray and all its items. The "contact/droplet" isolation sign on the resident's door indicated the required PPE before entry. CNA 32 did not perform hand hygiene, don an isolation gown, or place on gloves before she entered the room. In the room, CNA 32 set the kitchen tray down on top of the resident's individual refrigerator. She approached the resident's bed and rolled a bedside table full of personal belongings over to the resident. CNA 32 adjusted the height of the table and positioned it near the resident. She rearranged several personal items on the table with her bare hand to make room for the bowl of cereal and carton of milk which she placed on the table for the resident. At 10:40 a.m., CNA 32 exited the room with the tray, and did not perform hand hygiene. She took the tray to the B hall nurses' station and sat it down on the ledge of the nurses' station counter. During an interview on 1/5/22 at 5:34 p.m., the Regional Clinical Support RN indicated, the facility did not have written a covid policies because the guidance changed so frequently. She indicated the facility followed state health department and CDC (Centers for Disease Control) guidance.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

Indiana Department of Health Long-Term Care COVID-19 Toolkit, dated 12/14/21, indicated, " ...limit movement throughout facility during TBP, minimize resident's movement around the building, encouraging all residents in TBP to stay in their room or as in memory care consider placement in single room with dedicated HCP to care for this resident ... Outbreak testing plan: All close contacts without a history of COVID-19 in the previous 90 days should be tested at 2 days from exposure. If the test is negative, they should be tested again at 5-7 days from exposure. Unvaccinated or immunocompromised (U) residents should be placed in TBP for 14 days even if tested negative. Vaccinated (V) residents should be monitored for symptoms, they must mask in presence of others for 14 days. They should be placed in TBP if symptomatic or have a positive test ...."

Indiana Department of Health Long-term Care COVID-19 Clinical Guidance, dated 1/4/22, indicated, " ...Exposure or close contact is defined as an interaction for a cumulative total of 15 minutes or more in 24 hours, fewer than 6 feet distance with a known COVID-19 case starting from two days before the onset of symptoms or positive test if asymptomatic ...Residents with symptoms of COVID-19 at any time should be tested immediately and be placed in TBP until they meet criteria for discontinuation of TBP, irrespective of their vaccination status...
Residents with mild to moderate COVID-19 should be isolated in red zone for 10 days, and those with severe COVID-19 or immunocompromising condition for 20 days ...."

CDC Guidance titled, "Interim Infection Prevention and Control Recommendations to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Prevent SARS-CoV-2 Spread in Nursing Homes," dated 9/10/21, indicated, " ...a resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending. In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit ...." The immediate jeopardy that began on 1/4/22 was removed on 1/6/22 after the facility ensured all residents who tested positive for COVID-19 were moved to the Red Zone, TBP isolation signage was posted, staff received additional in-service and education about the proper use of, donning and doffing of PPE. The noncompliance remained at the lower scope and severity level of F of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. This Federal tag relates to Complaint IN00369620. 3.1-18(a)			