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	11/09/2021

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

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F 0000 Bldg. 00	This visit was for Investigation of Complaints IN00365903, IN00366019, and a COVID-19 Focused Infection Control Survey. Complaint IN00365903 - Substantiated. Federal/State deficiency related to the allegations is cited at F687. Complaint IN00366019 - Substantiated. Federal/State deficiencies related to the allegations are cited at F563, F580, and F656. Survey dates: November 5, 8, and 9 2021 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 5 Medicaid: 47 Other: 17 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 16, 2021.	F 0000		
F 0563 SS=D Bldg. 00	483.10(f)(4)(ii)-(v) Right to Receive/Deny Visitors §483.10(f)(4) The resident has a right to			

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

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	receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.			
	Based on interview and record review, the facility failed to ensure a resident's (Resident B) spouse was offered compassionate care visits for 1 of 3 residents reviewed for resident rights. Findings include: The clinical record for Resident B was reviewed	F 0563	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is prepared and	12/02/2021

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	on 11/5/21 at 1:08 p.m. Diagnoses included, but were not limited to, dementia, repeated falls, diabetes, and cognitive communication deficit. Review of the resident's admission record face sheet indicated he was married. The clinical record lacked documentation that compassionate care visits was offered to Resident B's spouse. During an interview on 11/9/21 at 9:54 a.m., the Social Services Director indicated the resident's spouse was not offered compassionate care visits. The Long-Term Care Newsletter 2020-72, dated 11/20/2020, included, but was not limited to, "As a reminder, the Essential Family Caregiver Program was launched by the state in June 2020. The program allows a family member or other outside caregiver...who provided regular care and support to the resident before the pandemic...to supplement the care and support to the resident during the public health emergency. This care and support should occur in the resident's room only and not in other areas of the long-term care facility...CMS's OSO 20-39 allows visitation even when indoor visitation is otherwise restricted...." This Federal tag relates to Complaint IN00366019. 3.1-8(a)		executed solely because federal and state law require it. Compliance has been and will be achieved no later than, the last completion date identified in the POC. Compliance will be maintained as provided in the plan of correction. Failure to dispute or challenge the alleged deficiency below is not an admission that the alleged facts occurred as presented in the statements. This report in its entirety has been reviewed by our quality Assurance Committee. **F563 Right to receive/Deny Visitors** 1. 1. Resident B no longer resides in the facility. 2. 2. Residents residing in the facility were identified by the Executive Director on 11/10/2021, as having the potential to be affected by the facility process for allowing residents access to visitors. *3.* On 11/10/2021, Director of Nursing and Executive Director reviewed the procedure for “visitation and compassionate care visits” and revised the process to include CMS Guidelines for visitation. Social Services sent emails to family	

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			members regarding the revised visitation process. On 11/10/2021, the Executive Director-initiated education with administrative staff regarding revised visitation guidelines. *(The administrative staff included the following participants: Director of Nursing, Assistant Director of Nursing, Social Services, Dietary Manager, Social Services, Business office Manager, MDS Coordinator, Therapy Director, Activity Director, Maintenance and Dietary Manager).* *4.* On 11/26/21, a **Visitation Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Executive Director /Designated Administrative Staff will complete random Visitor reviews using the Visitation Quality Review Tool, to validate that residents are provided visitation that allows immediate access to the resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; immediate access to the resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent	

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			at any time; reasonable access to a resident by any entity or individual that provides health, social, legal or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. The Visitation Quality Review will be completed on five residents a week for twelve weeks to ensure appropriate visitation allowance. Any concerns identified during the visitation reviews will be addressed at the time of the review and additional education will be completed at that time. Following the initial twelve-week audit, the Visitation Quality Review Audit will be completed on ten residents a month for four months. The results of these audits will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Audits will continue monthly until 100% compliance has been determined by the QAPI committee. *(For future reference the QAPI committee consists of the Medical Director, Director of Nursing and at least two of the following team members: Executive Director, Assistant Director of Nursing, Social*	

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			Services, Dietary Manager, Social Services, Business office Manager, MDS Coordinator, Therapy Director, Activity Director, Maintenance, Dietary Manage, licensed and certified staff). - Date of Completion-12/2/2021	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under			

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	paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure a resident's (Resident B) representative was notified in a timely manner when a fall occurred and the resident was sent to the hospital for 1 of 3 residents reviewed for family notification. Findings include: The clinical record for Resident B was reviewed on 11/5/21 at 1:08 p.m. Diagnoses included, but	F 0580	1. 1.Resident B no longer resides at the facility. 2. 2. On 11/10/21, The Director of Nursing identified residents who have fallen within the last thirty days and completed a clinical chart review for each resident identified to validate that following items were completed	12/02/2021

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	were not limited to, orthostatic hypertension, dementia, and repeated falls. The nurse's note, dated 10/18/21 at 2:22 a.m., indicated the resident was found sitting on the floor, on his buttocks, with a small laceration on the right eyebrow. The physician was notified with a new order to send the resident to the emergency room for evaluation. The nurse's note, dated 10/18/21 at 4:29 a.m., indicated the resident returned from the emergency room with 4 sutures above right eyebrow. The clinical record indicated the family was not notified of the fall until 10/18/21 at 11:30 a.m. During an interview on 11/8/21 at 4:45 p.m., Staff Member 4 indicated when a resident was sent to the hospital, the family should be notified at the time of transfer. On 11/5/21 at 4:18 p.m., the Director of Nursing provided a current copy of the document titled "Change in Resident's Condition or Status" and undated. It included, but was not limited to, "It is the policy of the facility to ensure that the resident's...Representative are notified of changes in the resident's condition...the nurse will notify the resident's representative when...The resident is involved in any accident or incident that results in an injury...It is necessary to transfer the resident to the hospital...." This Federal tag relates to Complaint IN00366019 3.1-5(a)(1)(4)		and documented in the clinical record; change of condition, MD notification, Responsible Party/Family notification of the event, and implementation of a comprehensive fall care plan. On 11/10/21, the Director of Nursing identified residents that were admitted to the facility within the last thirty days and completed a clinical chart review for each resident to validate that comprehensive fall care plans were implemented for residents identified as at risk for falls based on the fall risk evaluation. 3. On 11/26/21, the Director of Nursing /licensed nurse designee-initiated education with licensed nursing staff regarding residents' changes of condition including notification of the resident, immediate notification/consult with MD, notification, consistent with his/her authority, the resident representative when there is an accident. On 11/26/21 the Executive Director and Director of Nursing reviewed the policy for "Change in Resident Condition or Status" and found the policy to be acceptable. Licensed nursing staff are responsible for completing	

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			appropriate notifications. The protocol for reviewing accidents was revised to include a daily review Monday through Friday, by the intradisciplinary team, during the Morning Clinical Meeting to ensure appropriate notifications have been completed and documented in the resident's clinical record. 4. On 11/26/21, a **Change of Condition Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Executive Director /Designated Administrative Staff will complete random Change of Condition reviews using the Change of Condition Quality Review Tool, to validate notification of the resident, immediate notification/consult with MD, notification, consistent with his/her authority, the resident representative when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status (that is a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (that is a need to discontinue an existing	

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			form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility. The Change of Condition Quality Review will be completed on five residents a week for twelve weeks. Any concerns identified during the reviews will be addressed at the time of the review and additional education will be completed at that time. Following the initial twelve-week audit, the Change of Condition Quality Review Audit will be completed on ten residents a month for four months. The results of these audits will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Audits will continue monthly until 100% compliance has been determined by the QAPI committee. *(For future reference the QAPI committee consists of the Medical Director, Director of Nursing and at least two of the following team members: Executive Director, Assistant Director of Nursing, Social Services, Dietary Manager, Social Services, Business office*	

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			Manager, MDS Coordinator, Therapy Director, Activity Director, Maintenance, Dietary Manage, licensed and certified staff). - Date of Completion-12/2/2021	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).			

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	(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on interview and record review, the facility failed to ensure a fall comprehensive care plan was initiated timely for 2 of 3 residents reviewed for falls. Findings include: 1. The clinical record for Resident C was reviewed on 11/5/21 at 2:13 p.m. Diagnoses included, but were not limited to, dementia and difficulty walking. The resident was admitted on 9/13/21. The fall risk review, dated 9/13/21, indicated the resident was at a high risk for falls. The baseline care plan, dated 9/13/21, indicated the resident had a history of falls and that falls had occurred prior to admission.	F 0656	1. 1. On 11/16/21, the Director of Nursing Services reviewed Resident C and Resident D's comprehensive fall care plans and determined that the care plans were appropriate. 2. 2. On 11/10/21, The Director of Nursing identified residents who have fallen within the last thirty days and completed a clinical chart review for each resident identified to validate that following items were completed and documented in the clinical record; change of condition, MD notification, Responsible Party/Family notification of the event, and implementation of a	12/02/2021

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	The clinical record indicated the fall comprehensive care plan was not initiated until 10/14/21. During an interview on 11/8/21 at 4:58 p.m., the Director of Nursing indicated comprehensive care plans should be put in place within 21 days of admission. 2. The clinical record for Resident D was reviewed on 11/5/21 at 4:08 p.m. Diagnoses included, but was not limited to, unsteadiness on feet, dementia, Parkinson's disease, and history of falls. The resident was admitted on 10/7/21. The fall risk review, dated 10/7/21, indicated the resident had a history of falls within the last 3 months. The baseline care plan, dated 10/7/21, indicated the resident had a history of falls and that falls had occurred prior to admission. The clinical record indicated the fall comprehensive care plan was not initiated until 11/1/21. On 11/9/21 at 11:28 a.m., the Executive Director provided a current copy of the document titled "Baseline Care Plan Assessment/Comprehensive Care Plans" and undated. It included, but was not limited to, "Policy...The Comprehensive Care Plan will further expand on the resident's risks, goals and interventions...Procedure...The Comprehensive Care Plan will be finalized within 7 days of completion of the Full Comprehensive MDS (Minimum Data Set) assessments.... This Federal tag relates to Complaint		comprehensive fall care plan. On 11/10/21, the Director of Nursing identified residents that were admitted to the facility within the last thirty days and completed a clinical chart review for each resident to validate that comprehensive fall care plans were implemented for residents identified as at risk for falls based on the fall risk evaluation. On 11/11/2021, the Director of Nursing and MDS Coordinator reviewed comprehensive care plans for residents residing within the facility to determine if comprehensive care plans have been initiated within 21 days. Any resident identified as not having a comprehensive assessment completed was identified and a comprehensive care plan was developed during the review. *3.* On 11/24/21, Director of Nursing reviewed the procedure for “revising of care plans” and completion of comprehensive care plans. The process was revised to include increased monitoring care plans to validate that comprehensive care plans are updated as indicated with new orders and fall interventions. Care plans will be updated by the Director of Nursing Services, MDS Coordinator or licensed	

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	IN00366019 3.1-35(c)(1)		nursing designee. Physician orders will be reviewed daily Monday through Friday, by the intradisciplinary team, during the Morning Clinical Meeting to assure appropriate care planning is in place for new orders and fall prevention interventions. On 11/26/21, the Director of Nursing /licensed nurse designee-initiated education with licensed nursing staff regarding revision and implementation of resident care plans and following physician orders. (This education included fall prevention interventions and development of the comprehensive care plan within 21 days of admission). 4. On 11/26/21, a **Care Plan Development/Implementation Quality Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing /Designated Administrative Nursing Staff will complete random Care Plan reviews using the Care Plan Development/Implementation Quality Review Tool, to validate that care plans are being developed and implemented as indicated to meet resident needs including fall prevention interventions. This audit will also include monitoring to validate that	

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WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

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			comprehensive care plans are completed within the 21-day time frame allotted by the RAI guidelines. The Care Plan Development/Implementation Quality Review will be completed on five residents a week for twelve weeks. Any concerns identified during the reviews will be addressed at the time of the review and additional education will be completed at that time. Following the initial twelve-week audit, the Care Plan Development/Implementation Quality Review Audit will be completed on ten residents a month for four months. The results of these audits will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Audits will continue monthly until 100% compliance has been determined by the QAPI committee. - Date of Compliance-12/2/2021	
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care.			

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	To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. Based on observation, interview and record review, the facility failed to ensure resident's (Resident F and H) received podiatry care for 2 of 5 residents reviewed for foot care. Findings include: 1. The clinical record for Resident F was reviewed on 1/5/21 at 3:07 p.m. Diagnosis included, but was not limited to, diabetes. On 11/5/21 at 2:45 p.m., the following observation of Resident F's toenails were made with QMA (Qualified Medication Aide) 14: -Right foot The great toenail was extremely thick, yellow and rigged. The nail on the 2nd toe was long, thick, yellow and curved towards the great toe. The nail of the 3rd and 4th toes were yellow, long, and curved underneath the top of the toes. The nail on the 5th toe was long and curved towards the 4th toe. -Left foot The nail on the great toe was yellow and extremely thick. The nail on the 2nd toe was long, thick, yellow and curved towards the great toe.	F 0687	1. 1. Resident F was foot/nail care by licensed nursing staff on 11/5/21. Resident H was provided foot/nail care by licensed nursing staff on 11/8/21. Follow up podiatry has been scheduled by social services. 2. 2. Residents residing in the facility were identified by the Director of Nursing on 11/8/21 as having the potential to be affected by the facility process for foot care and podiatry services. Licensed nursing staff completed observations of resident and provided foot care if needed during the review. A list of residents with podiatry needs was submitted to the social worker. The social worker has contacted podiatry and scheduled a facility visit on 12/21/21. Any resident that consents to podiatry will be offered services at that time. 3. On 11/9/21, Director of	12/02/2021

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	The nail on the 3rd,4th, and 5th toes were observed to be long and extended beyond the top of the toes. The physician's order, dated 1/22/19, indicated the resident may be seen by the podiatrist. The clinical record indicated the resident was last seen by the podiatrist on 10/16/2019. During an interview on 11/5/21 at 2:45 p.m., QMA 14 indicated the podiatrist had not been in since COVID started. During an interview on 11/5/21 at 3:03 p.m., the Social Services Director indicated podiatrist had been coming in, but once COVID-19 came, they stopped coming in. They signed on a new podiatry company on May 1, 2021, however, they had not been in yet. She did not have any consents as the new company took care of the consents and treatment care. 2. The clinical record for Resident H was reviewed on 11/8/21 at 9:37 a.m. Diagnosis included, but was not limited to, diabetes. The resident was admitted on 10/16/20. On 11/5/21 at 3:36 p.m., the following observation of Resident H's toenails were made with the ADON (Assistant Director of Nursing): -Right foot The nail on the great toe was extremely long, yellow, and thick. The nail on the 2nd toe was thick and yellow. The nail on the 4th toe was thick. The nail on the 5th toe was long and thick. -Left foot The nail on the great toe was yellow, thick, and the nail bed was observed to be jagged.		Nursing and Executive Director reviewed the procedure for "Specialists visits" including podiatry services and revised the process to include monthly reporting by Social Services to the Executive Director regarding routine podiatry visits. On 11/27/21, the Executive Director-initiated education with social service staff regarding the revised process for reporting podiatry services/schedules. The Director of Social Services is responsible for monitoring podiatry needs, obtaining consents and implementing the schedule for routine services from podiatry. *4.* On 11/26/21, a **Foot Care/Podiatry Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing /Designated Administrative Nursing Staff will complete random Foot Care reviews using the Foot Care/Podiatry Quality Review Tool, to validate that residents are receiving appropriate foot care and podiatry services. The Foot Care/Podiatry Quality Review will be completed on five residents a week for twelve weeks to ensure appropriate foot care and referrals. Any concerns	

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	The nail on the 2nd toe was extremely thick and yellow. The nail on the 3rd toe was long, sharp, and curved over the top of the toe. The physician's order, dated 6/30/21, indicated the resident could be seen by the podiatrist. The clinical record lacked documentation of any podiatry visits. On 11/9/21 at 11:28 a.m., the Executive Director provided a current copy of the document titled "Physician/Physician Assistant/Nurse Practitioner/Clinical Nurse Specialist Visits" and undated. It included, but was not limited to, "Purpose...To ensure that all residents receive the care and services that meet their medical...needs. To ensure that all residents are seen regularly...." This Federal tag relates to Complaint IN00365903 3.1-47(a)(7)		identified during the reviews will be addressed at the time of the review and additional education will be completed at that time. Following the initial twelve-week audit, the Foot Care/Podiatry Quality Review Audit will be completed on ten residents a month for four months. The results of these audits will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Audits will continue monthly until 100% compliance has been determined by the QAPI committee. - Date of Completion- 12/2/2021	
F 9999 Bldg. 00	410 IAC 16.2-3.1-18 Infection control program Authority: IC 16-28-1-7 Affected: IC 16-28-5-1 Sec. 18. (b) The facility must establish an infection control program under which it does the following: (7) Reports communicable disease to public health authorities.	F 9999	1. 1. On 11/10/21 the Executive Director submitted a report to the Red Cap system showing positive results for staff members 5,6,7,8,and 9. 2. 2. No other reports were identified as missing in Red Cap during the survey review.	12/02/2021

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	Based on interview and record review, the facility failed to ensure COVID-19 positive staff were reported to the appropriate agency for 5 of 10 staff members reviewed for facility reporting. (Staff Members 5, 6, 7, 8, and 9) Findings include: Review of the line list for September 2021 and October 2021 indicated the following positive staff members: - On 09/11/21, Staff Member 5 tested positive for COVID-19. - On 09/12/21, Staff Member 6 tested positive for COVID-19. - On 10/07/21, Staff Member 7 tested positive for COVID-19. - On 10/18/21, Staff Member 8 tested positive for COVID-19. - On 10/18/21, Staff Member 9 tested positive for COVID-19. Review of the REDCap system lacked documentation that Staff Member 5, 6, 7, 8, and 9 had been reported. During an interview on 11/8/21 at 2:22 p.m., the Administrator indicated all of the positive staff had been reported, however, she did not have any confirmation. On 11/9/21 at 11:28 a.m., the Executive Director provided a current copy of the document titled "COVID-19 LTC Reporting Summary" dated 12/21/20. It included, but was not limited to, "Event...Positive COVID-19 Point-of-Care (POC) test - staff...Certified SNF/NF...Long-Term Care COVID-19 Reporting form (REDCap)/Within 24 hours of result...."		*3. On 11/9/21 the Executive Director and Director of Nursing reviewed the process for reporting data in the Red Cap system.* On 11/10/21, the Executive Director-initiated a tracking system for Red Cap reporting that requires all positive reports to be printed prior to submitting the positive results in the Red Cap system. Printing the report prior to submission will allow the facility to maintain proof of the report being made in the Red Cap system. *4.* On 11/26/21, a **Red Cap Review Audit** was reviewed and accepted by the Quality Assurance Performance Improvement Committee. The Director of Nursing /Designated Infection Control preventionist will complete random Red Cap reviews using the Red Cap Quality Review Tool, to validate that positive Covid tests are reported in the Red Cap reporting system within 24 hours of positive results. The Red Cap Quality Review will be completed five times a week for twelve weeks to ensure documentation is maintained to support Red Cap notifications Any concerns identified during the reviews will be addressed at the time of the review and additional	

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			education will be completed at that time. Following the initial twelve-week audit, the Red Cap Quality Review Audit will be completed on ten times a month for four months. The results of these audits will be submitted to the Quality Assurance Performance Improvement Committee monthly. The QAPI Committee will determine if additional education or competencies are required, based on the compliance reported from the Quality Reviews. Audits will continue monthly until 100% compliance has been determined by the QAPI committee.	