STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155608	A. BUILDING 00 B. WING	04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 19, 20, 21, 22, and 23, 2021. Facility number: 000515 Provider number: 155608 AIM number: 100290820 Census Bed Type: SNF/NF: 88 SNF: 19 Total: 107 Census Payor Type: Medicare: 27 Medicaid: 51 Other: 29 Total: 107 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/27/21.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an			

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

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	environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review and interview, the facility failed to ensure resident dignity was maintained related to an uncovered urinary catheter bag for 1 of 2 residents reviewed for dignity. (Resident 152) Finding includes:	F 0550	1.Upon surveyor notification of the missing catheter bag cover, the cover was immediately provided. 2.A review of all Residents with catheters was completed. No like circumstances were identified. 3.Education related to the	05/23/2021

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	On 4/19/21 at 9:51 a.m., Resident 152 was observed from the doorway of her room. She was in bed and an uncovered urinary catheter bag was observed hanging on the side of her bed with urine visible it it. On 4/21/21 at 11:58 a.m., the resident was observed seated in her room in a recliner. The urinary catheter bag was uncovered and laying directly on the floor next to her. The resident's record was reviewed on 4/19/21 at 10:20 a.m. A care plan, dated 4/13/21, indicated the resident had an indwelling urinary catheter. The care plan indicated the drainage bag should be covered to promote privacy. During an interview with the Administrator on 4/21/21 at 12:00 p.m., she indicated the catheter should have been covered. 3.1-3(a)		requirement for residents with catheters to have a cover provided has been completed for all nursing staff. An audit has been created to ensure that all residents with catheters have covers intact. 4.This audit will be completed by the DON or Designee 5 times per week for 6 weeks, biweekly for one month and weekly for the remainder of the 4 month period. The results of the aforementioned audit will be reviewed by the QAPI Committee for no less than 4 mos.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to correctly assess a resident as visually impaired for 1 of 2 residents reviewed for vision. (Resident 57) Finding includes: The record for Resident 57 was reviewed on 4/21/21 at 9:40 a.m. Diagnoses included, but were not limited to, heart disease, atrial fibrillation, and general weakness.	F 0641	1.The Care Plan for Resident 57 has been updated to include the need to obtain new glasses. 2. A review of all residents noted as having vision loss or hearing loss was completed to ensure there were no residents with lost or broken assistive devices. There were no like concerns identified. 3.Social Services Director or designee will review vision and	05/23/2021

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	The Minimum Date Set (MDS) Quarterly assessment, dated 3/12/21, indicated the resident was cognitively intact and had adequate vision with glasses. A Nursing Assessment, dated 3/9/21, indicated the resident's vision was adequate. A Nutrition Assessment, dated 3/12/21, indicated the resident's vision was adequate with glasses. A Social Service note, dated 7/14/20, indicated the resident's glasses were broken. During an interview with the resident on 4/19/21 at 9:28 a.m., he indicated he usually wore glasses, but his had broken about six months ago. He was unable to get new glasses due to COVID-19 restrictions. During an interview with MDS Nurse 1 on 4/21/21 at 2:40 p.m., he indicated he used information from the nursing and nutrition assessments for his MDS assessment. He was not aware the resident's glasses were broken and were not being used.		hearing needs during each initial/quarterly/annual MDS assessments to ensure Residents are receiving proper treatment and assistive devices to maintain vision and hearing abilities. An observation/review will be completed with each MDS assessment to ensure these needs are identified and appropriate follow through completed. These findings will be communicated to the MDS Coordinator. 4.The results of the aforementioned audit will be reviewed by the QAPI committee monthly for no less than 4 months to ensure compliance	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			

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	Based on observation, interview, and record review, the facility failed to ensure a resident received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 1 of 7 residents reviewed for non-pressure related skin conditions. (Resident 83) Finding includes: On 4/20/21 at 9:24 a.m., Resident 83 was observed lying in bed. She indicated she had an incident recently where she lost her balance and fell. She pulled back her blanket and showed she had large purple discolorations to her right outer thigh, the right knee, and the right calf. She indicated the staff were aware of her bruising to her right shoulder, but unaware if they knew about her leg and were monitoring it. She was also taking a blood thinning medication and bruised easily. On 4/21/21 at 10:02 a.m., Resident 83 was observed lying in bed. She indicated the bruising was still on her right leg and proceeded to pull the blanket back to show her leg. The purple discolorations were still observed to the right thigh, knee, and calf. On 4/22/21 at 3:06 p.m., Resident 83 was observed lying in bed. The resident indicated she was unaware if the nurses knew about her discolorations. The CNAs helped her get dressed, but the nurses had not come in to look at her leg. Interview with LPN 1 at the time, indicated she was unaware the resident had any discolorations to her right leg. She then proceeded to go into the resident's room to assess the discolorations.	F 0684	1.As it relates to Resident # 83 upon surveyor notification of identified skin discoloration the areas were immediately assessed. Treatment orders were received per MD. The Residents skin care plan and Braden assessment were updated per policy. 2.All Residents have the potential to be affected. Skin observations for all Residents have been completed. MD and Responsible party were notified of any identified concerns and appropriate treatment orders, care plans and Braden assessments updated. 3.All nursing staff has been educated on the policy related to skin check; including the requirement for nurses to observe skin once a week on shower days and the CNAs to make nursing aware of any areas of skin discoloration. An audit has been developed to ensure skin observations occur and appropriate follow up takes place. 4.The DON or Designee will review 10 Residents and 10 coinciding skin sheets weekly. The results of these skin checks will be reviewed by the QAPI committee monthly for 4 mos.	05/23/2021

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	She indicated the CNAs helped the resident get dressed and should have reported the resident's discolorations so they could have been assessed and monitored. Record review for Resident 83 was completed on 4/21/21 at 11:11 a.m. Diagnoses included, but were not limited to, anemia, coronary artery disease, and deep vein thrombosis (DVT) (blood clot). The Admission Minimum Data Set (MDS) assessment, dated 3/30/31, indicated the resident was cognitively intact. The resident required a 1 person assist for dressing and personal hygiene, and 2 + person assist with toilet use. The resident had received anticoagulant (blood thinning) medication. A Care Plan indicated the resident had a risk for skin integrity impairment related to mobility limitations, as well as the use of anticoagulant medication. An intervention included to assess skin when open or bruised area was noted. The Care Plan indicated she had a purple bruise to her right upper arm. A Care Plan indicated the resident was to be monitored for side effects of anticoagulant medication for the treatment of a DVT/PE (pulmonary embolism) (blood clot to the lungs). An intervention included to observe for increased bleeding tendencies which included bruising. The Physician's Order Summary (POS), dated April 2021, indicated an order for Eliquis (blood thinning medication) 5 mg (milligrams) twice a day for PE.			

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	The only skin discolorations documented in the resident's record were to her right buttock and right shoulder. The record lacked any documentation the discolorations to the resident's right thigh, right knee, or right calf had been assessed and were being monitored. 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, record review and interview, the facility failed to assist a resident to arrange an appointment for new glasses for 1 of 2 residents reviewed for vision. (Resident 57) Finding includes: On 4/19/21 at 9:28 a.m., Resident 57 was observed seated in his room. He was not wearing glasses. The resident's record was reviewed on 4/21/21 at 9:40 a.m. The Quarterly Minimum Data Set assessment, dated 3/12/21, indicated the resident	F 0685	1.Resident 57 optometry appointment took place on 5/12/21. 2. A review of all residents noted as having vision loss or hearing loss was completed to ensure there were no residents with lost or broken assistive devices. There were no like concerns identified. 3.Social Services Director or designee will review vision and hearing needs during each initial/quarterly/annual MDS	05/23/2021

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	had adequate vision with glasses and was cognitively intact. A Social Service note, dated 7/14/20, indicated the resident had broken his glasses. The note indicated, "....Will add to optometry list within facility but this is not an essential visit so optometry visit is on hold. Daughter voices understanding. Resident is aware of this as well..." During an interview with the resident on 4/19/21 at 9:28 a.m., he indicated he usually wore glasses, but his had broken about six months ago. He indicated he was unable to get new glasses due to COVID-19 restrictions. He also indicated he had received his COVID-19 vaccines. During an interview with the Social Service Director (SSD) on 4/21/21 at 2:40 p.m., she indicated the contracted provider who had come to the facility previously for eye exams no longer did that. She indicated if residents were vaccinated, the facility would make an appointment for them at an outside provider. She had forgotten the resident needed an appointment for new glasses. During a follow up interview with the SSD on 4/23/21, she indicated she had made an appointment next month for the resident to see an optometrist. 3.1-39(a)		assessments to ensure Residents are receiving proper treatment and assistive devices to maintain vision and hearing abilities. An observation/review will be completed with each MDS assessment to ensure these needs are identified and appropriate follow through completed. These findings will be communicated to the MDS Coordinator. 4.The results of the aforementioned audit will be reviewed by the QAPI committee monthly for no less than 4 months to ensure compliance	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic			

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	gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure a dependent resident had fluids accessible to maintain proper hydration for 1 of 1 residents reviewed for hydration. (Resident 14) Finding includes: On 4/19/21 at 10:13 a.m., Resident 14 was observed sitting in a chair in her room watching television. She had a bedside table next to her chair. There were no fluids for the resident to drink observed in the room. The resident indicated she was on thickened liquids and only received something to drink at meal times. On 4/21/21 at 9:58 a.m. and again at 2:22 p.m., Resident 14 was observed sitting in a chair in her room watching television. There were no fluids	F 0692	1.Upon surveyor notification of the resident requiring fluids, Resident 14 was provided with fluids per physicians orders. 2.All Residents have the potential to be affected. All Residents were provided with fluids per facility policy. 3.Education related to ensuring Residents have adequate fluids has been completed with all nursing staff. 4.An audit has been developed to ensure Residents are provided with water at a minimum of 3 times per day in addition to meal times. This Audit will be completed 3 times per week on various shifts. The results of this audit will be	05/23/2021

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	in the resident's room for her to drink. Record Review for Resident 14 was completed on 4/21/21 at 10:18 a.m. Diagnosed included, but were not limited to, stroke, hemiplegia (paralysis of one side of the body), and hypertension. The Significant Change Minimum Data Set (MDS) assessment, dated 1/7/21, indicated the resident was cognitively intact. The resident required a total assist of 1 person for locomotion, and a limited assist of 1 person for eating. The resident had a functional impairment on one side of upper and lower extremities for a limitation in range of motion. The Physician's Order Summary (POS), dated April 2021, indicated an order for nectar thick liquids. A Care Plan for Hydration Maintenance indicated the resident was at risk for fluid imbalance related to congestive heart failure, diuretic medication, dysphagia (difficulty swallowing foods or liquids), and right sided hemiparesis (paralysis on one side of the body). An intervention included to offer fluids with meals and medications and prn (when necessary). A Resident Care Guide indicated the resident was on nectar thick liquids. She could have thin liquids in a Provale Cup (cup that delivers small sips). Interview with LPN 2 on 4/21/21 at 2:22 p.m., indicated the resident was not on a fluid restriction diet. The resident was on thickened liquids and should have water available to her at all times. The resident could have water in a		reviewed by the QAPI committee on monthly basis for no less than 4 mos.	

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	special cup and she would make sure the resident was given one with water in it. Interview with Diet Tech 1 on 4/21/21 at 2:38 p.m., indicated the resident was not on a fluid restriction diet. The resident was on thickened liquids and should have water available to her at all times. 3.1-46(b)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure a resident received proper care and treatment related to oxygen administration flow rate for 1 of 3 residents reviewed for oxygen. (Resident 83) Finding includes: On 4/20/21 at 9:19 a.m., Resident 83 was observed lying in bed. The resident had oxygen on and infusing per a nasal cannula. The oxygen concentrator was on and set at 3.5 liters. On 4/21/21 at 11:13 a.m., Resident 83 was observed lying in bed. The resident had oxygen on and infusing per a nasal cannula. The oxygen	F 0695	1.Upon surveyor notification the oxygen flow rate for resident 83 was adjusted by the nurse to the correct liter flow per Physician's orders. 2.All residents with orders for oxygen have the potential to be affected. A review of all Residents Oxygen orders and oxygen tanks has been completed. No like circumstances were identified. 3.All Nurses have been educated to ensure that oxygen tank settings are consistent with Physicians orders. 4.An audit has been developed	05/23/2021

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	concentrator was on and set at 3.5 liters. CNA 1 was finishing giving the resident a bed bath. Interview with the resident at the time indicated she wasn't sure if she was supposed to be on 2 or 3 liters. Interview with the CNA at the time indicated the resident was supposed to be on 3 liters of oxygen. Record review for Resident 83 was completed on 4/21/21 at 11:11 a.m. Diagnoses included, but were not limited to hypertension, orthostatic hypotension, COPD (Chronic Obstructive Pulmonary Disease) and respiratory failure. The Admission Minimum Data Set (MDS) assessment, dated 3/30/31, indicated the resident was cognitively intact. The resident required a 1 person assist for dressing and personal hygiene, and 2+ person assist with toilet use. The resident had received oxygen therapy. A Care Plan indicated the resident needed oxygen to maintain her oxygen saturation levels due to having COPD with chronic hypoxic respiratory failure. An intervention included to administer oxygen as ordered. The Physician's Order Summary (POS), dated April 2021, indicated an order for oxygen therapy 2 liters continuously per nasal cannula. Interview with Nurse Supervisor 1 on 4/21/21 at 11:22 a.m., indicated the resident was supposed to be on 2 liters of oxygen and not 3.5 liters of oxygen. 3.1-47(a)(6)		to ensure that oxygen tanks are set to proper flow rate. The results of the aforementioned audit will be completed by the DON or designee 5 times per week for one month. 2 times per week for one month and weekly for 2 months to ensure compliance. The results of these audits will be reviewed by the QAPI Committee for no less than 4 mos.	
F 0727 SS=C	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON			

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Bldg. 00	§483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure there were 8 hours of consecutive RN (Registered Nurse) coverage for 2 out of 14 days reviewed. Findings include: On 4/23/21 at 1:05 p.m., the Nursing Staff Schedules, dated 4/4/21 through 4/17/21 were reviewed. There was an RN scheduled for 4 hours on 4/10/21 and no RN scheduled for 4/11/21. Interview with the Director of Nursing on 4/23/21 at 1:33 p.m. indicated there was not 8 hours of RN coverage on 4/10/21 and 4/11/21. 3.1-17(b)(3)	F 0727	1.The facility is unable to retrospectively address the cited concern. 2.The facility has signed a 6 week contract with an RN to ensure RN coverage for a minimum of 8 hours per day. Additional recruitment efforts continue. 3. The Scheduler and nurse managers have been educated on this requirement. The daily staffing sheet has been updated to include RN hours. The RN hours will be highlighted on the original schedule. Nurses have been educated to contact the DON if there is a call off that impacts RN hours. 4.The schedule will be reviewed at the end of each month for RN hours as required. The results of this review will be discussed at the	05/23/2021

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			QAPI committee meeting to ensure compliance for no less than 4 mos.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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			

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	be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review and interview, the facility failed to ensure infection control practices were in place related to a nasal cannula not changed as ordered, and a urinary	F 0880	1.Due to widespread non-compliance with PPE usage, all staff was educated on proper PPE needed throughout patient	05/18/2021

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	catheter bag and tubing laying on the floor. (Residents 152 and 84) The facility also failed to ensure infection control guidelines were in place and implemented to properly prevent and/or contain COVID-19 related to improper eye protection worn by staff within 6 feet of residents, and inappropriate personal protective equipment (PPE) worn in transmission based precaution (TBP) rooms for random observations for infection control throughout the facility. (Main Dining Room, 100 Hall, 200 Hall, 300 Hall) Findings include: 1. On 4/19/21, Resident 152 was observed in her bed. She had a nasal cannula on (for oxygen delivery) dated 4/8/21. On 4/21/21 at 11:58 a.m., the resident was observed seated in her room in a recliner. Her urinary catheter bag was uncovered and laying directly on the floor next to her. The nasal cannula she was using was dated 4/8/21. The resident's record was reviewed on 4/21/21 at 10:20 a.m. The resident was admitted to the facility on 4/6/21. A Physician's order dated 4/6/21, indicated the oxygen water and tubing was to be changed once a week. A facility policy titled, "Catheter Care, Urinary", dated 12/9/14, was received from the Director of Nursing on 4/21/21 at 1:40 p.m., indicated, "...Infection Control...b. Be sure the catheter and tubing are kept off the floor..." 2. On 4/19/21 the following was observed: - 11:51 a.m., LPN 1, Dietary Aide 1, and Dietary Aide 2 were observed serving lunch trays and drinks to residents in the main dining room. The		care areas. Res. 152's oxygen tubing and oxygen water bottle were changed and labelled appropriately Res. 152's and Res 84's urinary catheter bags and drainage tubings were placed at appropriate levels, lower than the bladder, and bags and tubings were positioned off of the floor. 2.All residents have the potential to be affected by improper use of PPE. All other residents with urinary catheter bags and supplemental oxygen use were identified by reports generated from EHR. 1.All staff was educated on proper PPE to be used, including facemasks and proper eyewear in all patient care areas, as well as use of proper mask and gowns in areas of transmission-based precautions. All residents with urinary catheters were observed for proper positioning of tubing and drain bags and improper placement was corrected. All residents with supplemental oxygen were observed for tubing and water bottle changes done weekly, with appropriate labelling and documentation in treatment record. Training completed by DON and IP. 1.Rounding will be done daily	

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	staff were wearing protective eye glasses but the glasses did not have any top or side coverage protection for the eyes. - 12:00 p.m., Environmental Services Aide 1 was observed in Room 210 talking with the resident and cleaning their room. The Aide was wearing protective eye glasses but the glasses did not have any top or side coverage protection for the eyes. -12:11 p.m., CNA 2 was observed going into Room 106 to deliver the resident their lunch tray. The resident was on the Yellow Zone of the facility and on Transmission Based Precautions (TBP). The Personal Protective Equipment (PPE) to be worn when entering the room was N95 or KN95 mask, eye protection, gown, and gloves. The CNA had her protective eye glasses on the top of her head instead of covering her eyes. She did not put on gloves and a gown before entering the resident's room to deliver her meal tray. Interview with the CNA when she left the room indicated she was aware the resident was on precautions and should have donned the appropriate PPE before entering the resident's room. -12:15 p.m., LPN 4 was observed going into Room 101 to administer the resident's medications. The resident was on the Yellow Zone of the facility and on TBP. The nurse was wearing protective eye glasses but the glasses did not have any top or side coverage protection for the eyes. Interview with the Executive Director on 4/19/21 at 12:22 p.m., indicated the staff should be wearing the appropriate PPE before entering any resident rooms when they are on TBP. She would ensure all staff had the appropriate eye protection to be worn.		for a minimum of 6 weeks by the DON or designee using rounding tools, to ensure staff compliance with current guidelines regarding PPE, proper positioning of urinary catheter tubing and bags, and weekly changing of oxygen tubing and water bottles; then 3 times per week for the remainder of 4 months total. Resident roster for urinary catheter and oxygen usage will be updated at least weekly. Results of rounding audits and compliance will be reviewed with regular QAPI committee meeting Monthly for 6 mos and further systemic changes will be made and monitored as a need is identified.	

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	3. On 4/21/21 at 9:51 a.m., Resident 84 was observed sitting in a chair in his room watching television. A catheter bag was observed underneath the chair with the bag and tubing on the floor. On 4/21/21 at 11:07 a.m., Resident 84 was still observed sitting in a chair in his room watching television. The catheter bag this time was off the floor but the tubing was still stretched out on the floor underneath his chair. Interview with LPN 5 at the time of the observation indicated the resident's catheter tubing should not be touching the floor and she would fix it. 4. On 4/22/21 at 10:02 a.m., Environment Services Aide 2 was observed going into Room 101 to clean the room. The resident was on the Yellow Zone of the facility and on TBP. The resident was observed lying in bed. The Aide was wearing a surgical mask and a face shield. She did not don a gown, gloves, or have a N95 or KN95 mask on. Interview with the Aide when she came out of the room indicated she was unaware the resident was on any precautions or what PPE she should have put on. She did not read the signs on the door before entering the room that indicated the resident was on TBP and what PPE staff should wear before entering the room. 5. During a continuous observation from 11:00 a.m.-12:06 p.m. on 4/19/21, in a "Green Zone" (there were not any residents in transmission based precautions), the following was observed on the 300 Hallway: a. CNA 3 and CNA 4 walked in and out of residents' rooms to provide care with improper eyewear. The glasses did not have any top or side coverage protection for the eyes.			

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	b. At 12:17 p.m. on 4/19/21 during the lunch meal tray pass, CNA 4 was observed to have her eyewear on top of her head while entering resident rooms 301 and 303. c. At 12:18 p.m. on 4/19/21, Environmental Service Aide 3 was observed wearing the correct eyewear, but the eyewear was not flush with her face with her glasses on while cleaning Room 311, where two residents resided. Interview on 4/19/21 with CNA 3 at 12:34 p.m., indicated she was told her eyewear were the proper eyewear due to the residents resided in the "Green Zone." Interview with an Environmental Service Aide 3 on 4/19/2021 at 12:34 p.m., indicated this was the eyewear she had received and was not aware she had worn them improperly. 6. On 4/19/2021 at 12:23 p.m. on the 200 Hallway, a resident was observed in her wheelchair being transported by MDS 1 without his face shield in place. Interview with MDS 1, on 4/19/2021 at 2:00 p.m., indicated the rules had changed so much, it was hard to remember on whether to wear the face shield or not. The Indiana State Department of Health, "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure", dated 10/19/20 and updated 4/7/2021 indicated, "...Masks and Eye Protection..There is emerging evidence that many persons with COVID-19 may only have mild symptoms or no symptoms at all. These persons, however, can still be infectious. In addition, CDC notes that transmission risks			

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	can be airborne for those infected with COVID 19. To prevent the spread of COVID-19 in your facilities among providers with no or mild symptoms, we recommend the following:..to provide essential direct care within 6 feet of the resident in all levels of care in all long-term care facilities and assisted living...COVID -19 Negative (Green)...HCP (Health Care Providers) will wear face mask (medical) and eye protection with face shield /or goggles as a standard safety measure to protect LTC. HCP (SNF/AL) who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status, when there is moderate to substantial (high) community transmission...Unknown COVID-19 status (Yellow): All residents in this category warrant transmission based precautions (droplet and contact.) HCP will wear single gown per resident, glove, N95 mask and eye protection (face shield/or goggles). Gowns and gloves should be changed after every resident encounter with hand hygiene performed...." 3.1-18(b)(2)			