STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF AVON	182 S COUNTY ROAD 550 E, AVON, , 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00366753 and IN00367335. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00366753 - Substantiated. No State Residential Findings related to the allegations were cited. Complaint IN00367335 - Substantiated. No State Residential Findings related to the allegations were cited. Survey dates: December 14 and 15, 2021. Facility number: 003902 Residential Census: 91 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 22, 2021.	R 0000	The submission of this Plan of Correction does not indicate an admission by Independence Village of Avon that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of Independence Village of Avon. To this end, the Plan of Correction shall serve as the credible allegation of compliance with all sate requirements governing the operations of this community.	

R 0406	Infection Control - Offense 410 IAC 16.2-5-12(a) (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview, and record review, the facility failed to prevent an outbreak of the novel Coronavirus (COVID-19) virus during a global pandemic when a dietary staff member who tested positive for COVID-19 failed to complete symptom screening before completing their shifts, and worked a shift after completing a screening with evidence of symptoms which resulted in a COVID-19 outbreak within the community with 5 of 5 positive residents being exposed to COVID-19 from dietary services and ultimately led to the death of 1 of 5 positive residents (Resident E). Findings include: During an interview, on 12/14/21 at 11:55 a.m., the Director of Nursing (DON) indicated the community had 5 residents who had recently tested positive for Covid, and 2 employees who	R 0406	**1.** **What corrective action(s) will be accomplished** **for those residents affected by the deficient practice?** Residents E, F, G, M and N were identified to have been affected. Resident E passed away. All other residents have tested negative for COVID-19 and continue to be monitored for signs and symptoms by shift. **2.** **How will the Community identify other** **residents having the potential to be affected by the same deficient practice** **and what corrective action will be taken?** The Community realizes that all residents coming into contact with a COVID-19 positive employee or resident have the potential to be affected by the alleged deficient practice. No other residents or employees were found	01/14/2022

	were positive as well. On 12/9/21, Resident E reported she did not feel well, had a runny nose, and loss of appetite. She was rapid tested for COVID-19, and the results were positive. The facility then began outbreak testing for residents that were contact traced from recent potential exposure to Resident E, mainly those who had eaten with her in the dining room. On the same day, two additional residents tested positive, Residents F and G. Outbreak testing continued on 12/13/21, and revealed two more residents tested positive, Residents M and N, which brought the total to 5 positive residents. The residents were all immediately quarantined in their apartments. It was determined the positive residents had been exposed by a positive staff person, a kitchen staff member (Server 8). During a general tour of the facility on 12/14/21 at 12:00 p.m., Resident E's room was observed from the hallway. There was a Red Stop Sign on her door with instructions to don, (put on) full droplet precaution Personal Protective Equipment (PPE). Resident E was heard coughing through the door intermittently. During an interview on 12/14/21 at 12:11 p.m., Certified Nursing Assistant (CNA) 4 indicated she		to test positive through Community-wide outbreak testing. All residents continue to be monitored for signs and symptoms of COVID-19 or other illness per shift. **3.** **What measures will be put into place or what systemic changes the Community will make to ensure that the deficient practice does not recur?** The systemic change will be the implementation of The COVID-19 Employee Screening Protocol along with three screening forms for employees and visitors. The screening will be a “Live” in person screening to ask the questions. (Please see Exhibit “A”). A staff In-service education was conducted on 12/16/2022. Topics were but not limited to: -Signs/symptoms of COVID-19 and screening questions	

	was from an agency nursing service and knew when she accepted her shifts, she would be working with the 5 COVID-19 positive residents. She rounded on each resident several times a day to check on them and delivered meal trays to each red room. CNA 4 indicated most of the residents were independent and did not need much help, but Resident E was more confused and required more frequent checks. She had COVID-19 symptoms such as loss of appetite, a cough, body aches and a runny nose. CNA 4 encouraged fluids as best she could, but the resident was weak and tired most of the time. On 12/14/21 at 1:03 p.m., an Emergency Medical Service (EMS) fire truck and ambulance arrived at the facility. On 12/14/21 at 1:15 p.m., EMS left with lights and sirens activated. During an interview on 12/14/21 at 1:35 p.m., Qualified Medication Aid (QMA) 6 indicated, Resident E had been sent out due to an acute onset of shortness of breath (SOB). On 12/14/21 at 1:50 p.m., the DON, Property Administrator and Interim Administrator provided copies of employee screening logs which they indicated were required to be		-Infection control (Please see Exhibit “B”). -Acknowledgement of the COVID-19 Employee Screening Protocol attestations. (Please see Exhibit “C” and “D”-sign in sheets). Education to staff will be conducted to review and implement the New Live Screening protocol. **How will the corrective action be monitored to ensure the deficient practice does not recur?**The Wellness Director or her designee will review the screening forms daily for the next thirty days, then 3 times weekly for the following thirty days and then weekly for the following thirty days to ensure compliance. Any negative findings will result in the appropriate disciplinary actions up to and including termination.	

completed by all staff members prior to shifts worked. The DON indicated, a kitchen staff member, Server 8, who was not vaccinated had not completed COVID-19 sign/symptom screening on 12/3/21 or 12/4/21. Additionally, when she completed screening on her last day worked in the facility, 12/6/21, she was positive for symptoms and self-reported a sore throat but continued to her shift without notifying her supervisor or another member of the leadership team. The DON indicated she worked on 12/6/21 as a server in the dining room. She carried meal trays for residents that could not carry trays themselves, she also assisted other residents by helping make their lunch plates, poured drinks, and waited on residents as needed.

On 12/14/21 at 1:57 p.m., a test attempt sign/symptom screening was completed at the front desk electronic kiosk with the DON and Interim Administrator present. A "TEST" name was entered. Employee was selected. A symptom of "sore throat" was selected, and a fever of 100.8 was entered. The last selection asked, "was this person cleared?" The answer "yes" was selected. No warning, prompts, or automatic restrictions were indicated.

During an interview on 12/14/21

at 2:00 p.m., the Property Administrator indicated the facility had plans to change their screening process and remove the ability to self-screen via electronic kiosk.

During an interview on 12/15/21 at 11:40 a.m., the Lead Receptionist indicated all incoming employees and visitors were required to completed COVID-19 sign and symptom screening before going into the community to help prevent the spread of Covid. The facility utilized a self-screening kiosk was located in the front lobby, it was an iPad with screening questions and an automatic digital thermometer. Each person needed to screen themselves in by answering a series of questions and checking their temperature. The Lead Receptionist and other receptionist assistants did not have access to the program and were not able to run reports on completed screens to ensure compliance. If someone came in with symptoms or a fever they should not go into the community, but the Lead Receptionist did not know if the kiosk restricted that visitor or gave instructions for further assessment.

The next morning, on 12/15/21 at 9:00 a.m., during a follow up interview to inquire upon the condition of Resident E, the

DON indicated she had passed away shortly after her arrival to the hospital.

During a follow up interview on 12/15/21 at 9:22 a.m., QMA 6 indicated a more detailed account of the incident he observed the previous day. QMA heard a distress call over the radio, "please come help, now! Now! Now!" He went to Resident E's room. The door was open when he arrived at Resident E's room. She was still conscious at that time but coughing badly and it sounded like she struggled to get whatever it was out of her chest. QMA 6 could hear the rattle of phlegm in her chest and throat. 911 got there and her cough got worse, there was a look of distress across her face, and she started to go limp and turn blue. 911 rushed her out.

During an interview on 12/15/21 at 9:26 a.m., Licensed Practical Nurse (LPN) 7 indicated she was the nurse on duty when Resident E had a decline in her condition. She was alerted by CNA 4 to come fast. Resident E was in her wheelchair in the bathroom coughing. CNA 4 indicated, Resident E was fine when she assisted her to the toilet, but when she went to help move her off the toilet she started coughing, stared off, and made a strange, gargled sound. LPN 7 immediately assessed

her by checking her vital signs. Her Oxygen saturation (02 sats) level at that time was 87. Resident E had a physician order to be sent out for any 02 sats less than 91 so she was going to send her out anyway. Resident E continued to cough, then she began to vomit, she moaned, and nodded in and out of consciousness. EMS got there, put her on a gurney and took her out fast.

On 12/15/21 at 12:00 p.m., a medical record review was completed for Resident E. She was a 93-year-old resident with active diagnoses which included but were not limited to hypertension (high blood pressure), and dementia. She had completed the COVID-19 vaccination series but had not received the third booster shot.

A nursing progress note, dated 12/9/21 at 6:37 p.m., indicated a CNA reported Resident E had not eaten lunch and stated she was not feeling well. The nurse assessed Resident E and found she had a temperature of 99.1, a runny nose, and indicated she did not feel "good." A rapid Covid test was performed and indicated Resident E was positive for the virus.

A nursing progress note, dated 12/10/21 at 3:00 p.m., indicated Resident E was in isolation. She was lethargic and did not eat

lunch.

A nursing progress note, dated 12/12/21 4:01 p.m., indicated, Resident E remained on contact isolation. Her 02 sats were 92%, but no shortness of breath (SOB) was noted. Resident E complained she did not feel well and according to the CNA, she had not urinated all day.

A nursing progress note, dated 12/14/21 at 6:45 a.m., indicated Resident E's 02 sats remained at 91%.

A nursing progress note, dated 12/14/21 at 1:29 p.m., indicated Resident E had been sent to the ER due to convulsions, vomiting, and had become unresponsive. Her 02 sats dropped to 87%.

A nursing progress note, dated 12/14/21 at 4:30 p.m., indicated Resident E had passed away.

During an interview on 12/15/21 at 11:45 a.m., the DON indicated she did not have COVID-19 specific training or in-service records from Server 8 other than general, initial-hire infection control training that addressed handwashing/hygiene. The facility had been in the process of implementing new training requirements for COVID-19 education but could not see that Server 8 had been educated.

On 12/15/21 at 10:00 a.m., the DON provided a copy of current facility policy titled, "SARS-CoV-2 Infection Prevention and Control Program (COVID-19)" dated 10/21/21. The policy indicated, "The community shall maintain a strong infection prevention and control (ICP) program to protect both residents and employees from SARS-Cov-2... Education for residents HCP (health care providers [direct care staff]) and visitors about SARS-Cov-2: HCP (including volunteers and consultant personnel): signs and symptoms that could signal infection, recommended practices to prevent spread of SARS-Cov-2, remind not to report to work when ill, and updates for guidance changes...."

On 12/15/21 at 10:00 a.m., the DON provided a copy of current facility policy titled, "COVID-19 Employee Screening Protocol," dated, 4/3/20. The policy indicated, "Greet person verbally and from a safe social distance of six (6) feet or more. Ask them to sanitize hands using alcohol-based hand rub. Screening for signs and symptoms, conduct the following: take temperature of person. If equal to or greater than 100.0 degrees Fahrenheit, turn employee away... Ask, "in the past 14 days, have you had any of the following symptoms:

fever, body aches, chills, cough, sore throat, extreme fatigue, loss of taste and smell, difficulty breathing or digestive symptoms such as diarrhea, vomiting or abdominal pain? a. If they have had and of the above symptoms in the last 72 hours, turn employee away. b. If they have, but believe its related to a non-contagious illness, get the ED (executive Director) involved...."

Based on observation, interview, and record review, the facility failed to prevent an outbreak of the novel Coronavirus (COVID-19) virus during a global pandemic when a dietary staff member who tested positive for COVID-19 failed to complete symptom screening before completing their shifts, and worked a shift after completing a screening with evidence of symptoms which resulted in a COVID-19 outbreak within the community with 5 of 5 positive residents being exposed to COVID-19 from dietary services and ultimately led to the death of 1 of 5 positive residents (Resident E).

Findings include:

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Covid, and 2 employees who were positive as well. On 12/9/21, Resident E reported she did not feel well, had a runny nose, and loss of appetite. She was rapid tested for COVID-19, and the results were positive. The facility then began outbreak testing for residents that were contact traced from recent potential exposure to Resident E, mainly those who had eaten with her in the dining room. On the same day, two additional residents tested positive, Residents F and G. Outbreak testing continued on 12/13/21, and revealed two more residents tested positive, Residents M and N, which brought the total to 5 positive residents. The residents were all immediately quarantined in their apartments. It was determined the positive residents had been exposed by a positive staff person, a kitchen staff member (Server 8).

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Assistant (CNA) 4 indicated she was from an agency nursing service and knew when she accepted her shifts, she would be working with the 5 COVID-19 positive residents. She rounded on each resident several times a day to check on them and delivered meal trays to each red room. CNA 4 indicated most of the residents were independent and did not need much help, but Resident E was more confused and required more frequent checks. She had COVID-19 symptoms such as loss of appetite, a cough, body aches and a runny nose. CNA 4 encouraged fluids as best she could, but the resident was weak and tired most of the time.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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