STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE, MERRILLVILLE, , 46410

(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 IN00358405, IN00362089 and IN00362136. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00358405 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00362089 - Unsubstantiated due to lack of evidence. Complaint IN00362136 - Substantiated. State deficiencies related to the allegations are cited at R0273 and R0407. Survey dates: September 20 & 21, 2021 Facility number: 014178 Residential Census: 114 These state residential findings are cited in accordance with 410	R 0000	This Plan of Correction constitutes our written allegation of compliance for the deficiency cited, however, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet established state and federal law.	

	IAC 16.2-5. Quality review completed on 9/22/21.			
R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure State and local sanitation and safe food handling standards were followed, related to lack of hair coverings for 4 of 5 kitchen staff (Dietary Aides 1, 2, 3, and 4) and lack of handwashing during a noon meal for 1 of 4 Dietary Aides observed. (Dietary Aide 5). This had the potential to affect all 114 residents receiving food from the kitchen. Findings include: 1. During an observation of the supper meal on 9/20/21 at 5:10 p.m., a sign on the kitchen door indicated hair nets were to be worn by all staff who entered the kitchen. Dietary Aides 1, 2, and 3 were observed in the kitchen and drink prep areas without hair nets or hair covers. The	R 0273	Belvedere Senior Housing Facility #: 014178 Survey Date: 09/21/2021 Plan of Correction **R -273 Food and Nutritional Services** –Deficiency 1. No residents were affected by alleged deficient practice. Dietary staff on duty were given and wearing hairnets after found without hairnets. 2. All residents have the potential to be affected, however no adverse reactions occurred under this deficiency. 3.	10/20/2021

	Dietary Manager indicated at the time of the observation, that the staff were aware they had to wear hair nets. On 9/20/21 at 5:13 p.m., Dietary Aide 4 then entered the kitchen with her hair net covering only the back of her head. An undated "Culinary Manual", received from the Dietary Manager on 9/21/21 at 2:26 p.m., indicated caps/hats or hairnets must be worn in the kitchen.		The dietary staff were re-inserviced on 9/24/2021 and 9/27/2021 by the Dietary Director on sanitation/safe food handling standards to include hairnets and proper handwashing /gloves protocols to ensure safe food and handling standards. 4. A QA audit will be conducted 3 x week for 8 weeks and then weekly x 4 months by the Dietary Manager/designee. Monthly audits will be reviewed at the Quarterly QA meeting for review and recommendations. Date of Completion: 10/20/2021	

	2. During an observation of the lunch meal on 9/20/21 at 12:09 p.m., Dietary Aide 5 had gloves on and was clearing soiled dishes from the tables when residents were through eating. She was touching the soiled plates, cups, utensils and napkins. She then placed sacks, used for individual resident trash, and covered utensils on the tables for the residents awaiting their lunch meal, without removing the gloves and washing her hands. A resident then asked for a drink and she filled a glass with ice from the machine an retrieved a drink for the resident in the same gloves. During an interview at the time of observation, Dietary Aide 5 indicated when she went into the kitchen she changed gloves and washed her hands. Dietary Aide 5 had not gone into the kitchen during the observation. An undated, "Culinary Manual", received from the Dietary Manager on 9/21/21 at 2:26 p.m., indicated hands were to be washed after handling soiled equipment or utensils and after hands were contaminated. This Residential tag relates to Complaint IN00362136. Based on observation, record review, and interview, the facility failed to ensure State and local sanitation and safe food handling standards were			

followed, related to lack of hair coverings for 4 of 5 kitchen staff (Dietary Aides 1, 2, 3, and 4) and lack of handwashing during a noon meal for 1 of 4 Dietary Aides observed. (Dietary Aide 5). This had the potential to affect all 114 residents receiving food from the kitchen.

Findings include:

1. During an observation of the supper meal on 9/20/21 at 5:10 p.m., a sign on the kitchen door indicated hair nets were to be worn by all staff who entered the kitchen. Dietary Aides 1, 2, and 3 were observed in the kitchen and drink prep areas without hair nets or hair covers. The Dietary Manager indicated at the time of the observation, that the staff were aware they had to wear hair nets.

On 9/20/21 at 5:13 p.m., Dietary Aide 4 then entered the kitchen with her hair net covering only the back of her head.

An undated "Culinary Manual", received from the Dietary Manager on 9/21/21 at 2:26 p.m., indicated caps/hats or hairnets must be worn in the kitchen.

2. During an observation of the lunch meal on 9/20/21 at 12:09 p.m., Dietary Aide 5 had gloves on and was clearing soiled dishes from the tables when residents were through eating.

	She was touching the soiled plates, cups, utensils and napkins. She then placed sacks, used for individual resident trash, and covered utensils on the tables for the residents awaiting their lunch meal, without removing the gloves and washing her hands. A resident then asked for a drink and she filled a glass with ice from the machine an retrieved a drink for the resident in the same gloves. During an interview at the time of observation, Dietary Aide 5 indicated when she went into the kitchen she changed gloves and washed her hands. Dietary Aide 5 had not gone into the kitchen during the observation. An undated, "Culinary Manual", received from the Dietary Manager on 9/21/21 at 2:26 p.m., indicated hands were to be washed after handling soiled equipment or utensils and after hands were contaminated. This Residential tag relates to Complaint IN00362136.			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms.	R 0407	Belvedere Senior Housing Facility #: 014178 Survey Date: 09/21/2021	10/20/2021

(2) Provides orientation and in-service education on infection prevention and control, including universal precautions.

(3) Offering health information to residents, including, but not limited to, infection transmission and immunizations.

(4) Reporting communicable disease to public health authorities.

Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented to properly prevent and or contain COVID -19, related to staff not wearing facial masks appropriately, visitors entering the building without screening and without a mask, and employees not screened prior to working. (Dietary Aides 1, 2, 3, 4, CNAs 6, 11, 12, and QMAs 7,8,9, and 10). This had the potential to affect 114 of 114 residents who reside in the facility.

Findings include:

1. During an observation on 9/20/21 at 5:08 p.m., CNA 6 and Dietary Aide 2 were in the Dining Room. There were residents present. CNA 6's and Dietary Aide 2's facial masks were below their noses.

At 5:10 p.m., Dietary Aide 1 was in the Dining Room in the drink

Plan of Correction

R -407 Infection Control – Non Compliance - Deficiency

Corrective Action:

1.
No Residents were negatively affected by alleged deficient practice.

CNA 6 and Dietary Aide 1 and 2 was immediately instructed and re-educated to wear face masks properly.

2.
All residents had potential to be affected by the lack of screening/attestation forms not being filled out and monitored or from the improper use of surgical masks.

3.
Staff was re-inserviced on 9/24/2021 and 9/27/2021 on the requirement of the attestation forms for visitors and staff as

	prep area with her facial mask pulled down to her chin. The Dietary Manager and Dietary Aide 3 were in the kitchen, Dietary Aide 3's mask was pulled down below her nose. Dietary Aide 4 entered the kitchen at 5:13 p.m. with her mask below her nose. A facility policy, titled, "Community COVID-19 Plan", dated 7/8/21 and received from the Regional Nurse as current, indicated the facility would ensure that employees wear face masks. Face masks were to be worn by employees over the nose and mouth when they were indoors. 2. The facility was entered on 9/20/21 at 5:08 p.m. There were no staff at the front door to oversee the screening process for COVID-19. There were three binders at the desk to be used for self screening, one binder for vaccinated staff, one binder for unvaccinated staff, and one binder for visitors. There was an electronic thermometer located on the wall so the temperature could be monitored. On 9/20/21 at 5:45 p.m., three masked visitors entered the front door, one of the three visitors stopped to self screen self, the other two visitors continued to walk past the front desk without being screened for signs and symptoms of		well as proper positioning of the surgical masks when working with residents or around unvaccinated staff. Additional signage was placed on front doors and at reception desk as well as box of surgical masks. 4. A QA audit will be conducted by the DON/Administrator and/or designee 3 times a week x 8 weeks then weekly for 4 months or until CDC guideline change to staff are following the CDC guidelines with monitoring and completing attestation forms for visitors and staff as well as wearing surgical masks properly. Date of Completion: 10/20/2021	

COVID-19. No staff were present to monitor visitor entry.

On 9/20/21 at 5:48 p.m., a visitor without a mask entered the building and walked past the front desk without being screened for signs and symptoms of COVID-19. No staff were present to monitor visitor entry.

3. During an interview on 9/21/21 at 8:42 a.m., the Receptionist indicated anyone who entered the building was screened for COVID-19 signs and symptoms. The staff completed self screening and she was unsure who checked the screens to ensure all the staff were screened and there were no signs and symptoms of COVID-19 present.

The Staff Screening Forms, dated 9/20/21, were compared to the schedules of the Nursing and Dietary Staff on 9/20/21 at 1:26 p.m. Dietary Aides 1, 2, 3, 4, CNA's 6, 11, 12, and QMA's 7,8,9, and 10 had worked on 9/20/21 and had not been screened for signs and symptoms of COVID-19. The Administrator indicated it was her responsibility to ensure the staff were screened and the forms were filled out.

On 9/20/21, the county positivity rate was 10.08% per the CDC Covid Data Tracker website.

A facility policy, titled, "Universal Screening Policy", dated 8/17/21, and received from the Regional Nurse as current, indicated all employees were expected to complete an Employee Attestation at the beginning of their shift. The Administrator or designee were responsible for monitoring the appropriate completion and compliance. All visitors were to complete the Visitor Attestation Form upon arrival to the facility. A staff member, assigned by the Administrator or designee were to review the attestation forms.

The Indiana Department of Health (IDOH) COVID-19 LTC Facility Infection Control Guidance

Standard Operating Procedure (SOP), updated 7/23/21, indicated the following:

".... PREVENT THE INTRODUCTION OF COVID-19 INTO YOUR FACILITY:

Long-term care centers should take everyday preventive measures to help contain the spread of COVID-19.

- Actively screen [monitored by a person] all healthcare personnel (HCP), visitors, vendors entering the facility for symptoms of COVID 19 and any history of being a close contact or exposed to COVID 19 positive or symptomatic person

.... "

The Indiana Department of Health Adjunct IDOH Guidance: LTC Facilities Guidelines in Response to COVID-19 Vaccination, updated 7/29/21, indicated, "...This will directly impact all visitors, healthcare personnel and residents at LTC, skilled nursing facilities and assisted living facilities. Masks are required for all when the county positivity rates are above 5% per Indiana Department of Health (IDOH) current guidance and risk assessments...."

This Residential tag relates to Complaint IN00362136.

Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented to properly prevent and or contain COVID -19, related to staff not wearing facial masks appropriately, visitors entering the building without screening and without a mask, and employees not screened prior to working. (Dietary Aides 1, 2, 3, 4, CNAs 6, 11, 12, and QMAs 7,8,9, and 10). This had the potential to affect 114 of 114 residents who reside in the facility.

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Dining Room. There were residents present. CNA 6's and Dietary Aide 2's facial masks were below their noses.

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masked visitors entered the front door, one of the three visitors stopped to self screen self, the other two visitors continued to walk past the front desk without being screened for signs and symptoms of COVID-19. No staff were present to monitor visitor entry.

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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