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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS AT 56TH	4940 WEST 56TH STREET, INDIANAPOLIS, , 46254

(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 Complaint IN00369332 and IN00369700. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00369332 - Substantiated. State deficiencies related to the allegations are cited at R36, R270, R406, and R413. Complaint IN00369700 - Substantiated. State deficiencies related to the allegations are cited at R36 and R91. Unrelated deficiencies are cited. Survey dates: January 5, 6 & 7, 2022 Facility number: 14279 Residential Census: 110	R 0000	POC Complaints (IN00369332, IN00369700) January 5-7, 2021 I would respectively request a desk review.	

	These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 13, 2022			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) 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. Based on interview and record review, the facility failed to inform residents, their representatives, and families of how the facility is handling issues with care and staff shortages, general information about COVID-19, the number of residents and staff who have tested positive and the number of "new" positive cases (those in the last 14 days), the number of residents who have died due to the virus, and facility mitigation actions implemented to reduce	R 0036	R036 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Notifications were sent out on Jan. 11 regarding COVID 19 updates and to keep families informed. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents had the potential to be affected by this deficient practice. Notifications were sent out on Jan. 11 regarding COVID 19 updates and to keep families informed. These notifications will be sent	01/24/2022

	the risk of COVID-19 transmission, including if normal operations of the facility have to be altered, at least weekly and if needed, more often for 110 residents residing in the facility, their representatives, and families. Findings include: A copy of the facility's mechanism used to communicate with residents, their representatives, and families of confirmed or suspected COVID-19 cases in the facility and mitigation actions was provided by ED (Executive Director) on 1/7/22 at 1:57 p.m. The last COVID-19 update was sent on 12/28/21 at 1:04 p.m. It indicated, a new resident COVID-19 case was identified, follow up testing to occur, and visitation still occur. The notification did not address staffing shortages if any, give general information regarding COVID, or the number of residents and staff who have tested positive in the last 14 days. An interview with ED was conducted on 1/7/22 at 1:40 p.m. ED indicated, the residents are informed of current cases of COVID by word of mouth and the representatives/families are notified by email. ED indicated, the COVID email had not been sent out, until 12/28/21, since		out weekly -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The administrator and DON/designee will meet weekly to confirm the proper COVID19 status communication update has been sent out via Caremerge per guidelines. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will	

	December 2020. ED further stated, they have had positive staff cases of COVID-19 during that time frame. The Indiana State Department of Health's Informing Family Members during COVID-19, last updated on 3/15/21, indicated, "State Department of Health (ISDH) is requiring long-term care facilities (nursing facilities, skilled nursing facilities, residential facilities and assisted-living facilities) to provide to residents and their designated representatives the following: 1. How the facility is handling issues with care and staff shortages 2. General information about COVID-19 3. The number of residents and staff who have tested positive and the number of "new" positive cases (those in the last 14 days) 4. The number of residents who have died due to the virus 5. Facility mitigation actions implemented to reduce the risk of COVID-19 transmission, including if normal operations of the facility have to be altered... The guidelines for cumulative updates to residents, designated representatives, and		be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** January 24, 2022	

	families is changing from daily to weekly. In addition, anytime a confirmed COVID-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other the facility must communicate this to residents, designated representatives and families by the next calendar day." This state residential finding relates to complaint IN00369332 and IN00369700. Based on interview and record review, the facility failed to inform residents, their representatives, and families of how the facility is handling issues with care and staff shortages, general information about COVID-19, the number of residents and staff who have tested positive and the number of "new" positive cases (those in the last 14 days), the number of residents who have died due to the virus, and facility mitigation actions implemented to reduce the risk of COVID-19 transmission, including if normal operations of the facility have to be altered, at least weekly and if needed, more often for 110 residents residing in the facility, their representatives, and families. Findings include:			

	A copy of the facility's mechanism used to communicate with residents, their representatives, and families of confirmed or suspected COVID-19 cases in the facility and mitigation actions was provided by ED (Executive Director) on 1/7/22 at 1:57 p.m. The last COVID-19 update was sent on 12/28/21 at 1:04 p.m. It indicated, a new resident COVID-19 case was identified, follow up testing to occur, and visitation still occur. The notification did not address staffing shortages if any, give general information regarding COVID, or the number of residents and staff who have tested positive in the last 14 days. An interview with ED was conducted on 1/7/22 at 1:40 p.m. ED indicated, the residents are informed of current cases of COVID by word of mouth and the representatives/families are notified by email. ED indicated, the COVID email had not been sent out, until 12/28/21, since December 2020. ED further stated, they have had positive staff cases of COVID-19 during that time frame. The Indiana State Department of Health's Informing Family Members during COVID-19, last updated on 3/15/21, indicated, "State Department of Health (ISDH) is requiring long-term			

	care facilities (nursing facilities, skilled nursing facilities, residential facilities and assisted-living facilities) to provide to residents and their designated representatives the following: 1. How the facility is handling issues with care and staff shortages 2. General information about COVID-19 3. The number of residents and staff who have tested positive and the number of "new" positive cases (those in the last 14 days) 4. The number of residents who have died due to the virus 5. Facility mitigation actions implemented to reduce the risk of COVID-19 transmission, including if normal operations of the facility have to be altered... The guidelines for cumulative updates to residents, designated representatives, and families is changing from daily to weekly. In addition, anytime a confirmed COVID-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other the facility must communicate this to residents, designated representatives and families by the next calendar			

	day." This state residential finding relates to complaint IN00369332 and IN00369700.			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to implement the incident policy and the fall prevention and management policy for 3 of 4 residents reviewed for falls. (Residents B, D, and F) Findings include: 1. A nursing note dated 12/7/21 at 9:15 p.m. indicated, "Resident had unwitnessed fall. she was found on the floor in	R 0091	R091 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B: Emergency contact was updated in our system Resident D: Emergency contact info was verified as accurate in our system. Incident form will be completed per policy and accurately for any future incidents. Resident F: Emergency contact info was verified as accurate in our system. Incident form will be completed per policy and accurately for any future incidents.	01/24/2022

	her room. Stated to the writer, she stepped on her rob[sic] while backing out from the bathroom...Unable to contact family. Phone not responding..." The incident/accident report was undated with a time of incident of 7:30 p.m. and contained a description of a fall that was related to the nursing note. The report did not indicate the emergency contact was notified as the section was left blank. A nursing note dated 12/12/21 at 10:37 a.m. indicated, "Nurse received resident on the floor in her room at approximately 10am[sic], resident states she fell in the middle of the night but couldn't find her call bell to notify staff. An interview with Resident B was conducted on 1/7/22 at 11:27 a.m. Resident B indicated, on 12/12/21, "I was trying to get up to go to the bathroom and I remember it was dark outside. I think it was about 2 a.m. and I didn't have on the non slip socks and I slid down and hit my right upper arm/shoulder area and hit my head on the floor. The nurse in the morning came in to give me my medicine and that is how they found me. My call light button was not near me and honestly, I'm not even sure help would have come."		-**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents had the potential to be affected by this deficient practice. DON/designee will review all fall/incident reports weekly to confirm they are being completed per policy. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee will review all fall/incident reports weekly to confirm they are being completed per policy. DON re-educated nursing staff on 1/10/22 on the completion of incident/fall forms and the fall/incident policy.	

	An interview with Resident B's daughter was conducted on 1/7/22 at 11:20 a.m. She indicated, she had not been notified of either the 12/7/21 fall nor the 12/12/21 fall. An interview with DON (Director of Nursing) was conducted on 1/6/22 at 9:51 a.m. indicated, she was unable to locate an incident/accident report for Resident B's 12/12/21 fall. 2. The clinical record for Resident D was reviewed on 1/5/22 at 10:56 a.m. Resident D's diagnoses included, but not limited to, major depressive disorder, history of falling, muscle weakness, and emphysema. A nursing note dated 12/15/21 at 7:03 a.m. indicated, Resident B was found sitting on the floor in her room. She stated she had fallen on her way to the bathroom and hit the back of her head on the bed resulting in an open area the back of her right arm. The incident/accident report for Resident D dated 12/15/21 was received from DON (Director of Nursing) on 1/5/21 at 2:21 p.m. The incident/accident form did not indicate Resident D's physician had been notified of her fall as that section of the form was blank. A nursing note dated 12/29/21		-**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** January 24, 2022	

	at 9:41 a.m. indicated, Resident D was found on the floor next to her recliner chair and was unable to stand. The nurse called 911 for assistance with getting Resident D up. Resident D refused to go to the emergency room for follow up. The incident/accident report for Resident D's fall on 12/29/21 did not indicate her emergency contact was notified of her fall as that section of the form stated "unable to locate". An incident/accident report dated 1/1/22 indicated Resident D had a fall at 12:30 p.m. It stated, "Resident states, getting ice, lost balance, grabbed the freezer door and the 'whole thing' came down. 911 called to transfer to [sic, local hospital]". The incident form did not indicate her emergency contact was notified of her fall as that section of the form stated, "unable to find". 3. An incident/accident report dated 12/8/21 for Resident F was received from DON on 1/5/22 at 2:21 p.m. It indicated, "Resident was found on the floor laying[sic] with pillow under her head. Alert and oriented x 3. Resident stated to the writer that she fell since [sic] midnight while going to the bathroom..." The incident report did not indicate Resident F's physician was notified of her fall as that			

	section of the form stated, "n/a" [sic, not applicable]. A review of Resident F's clinical record was conducted on 1/6/21 at 9:41 a.m. Resident F's clinical record did not contain a fall risk assessment. An interview with Resident F was conducted on 1/7/22 at 10:23 a.m. Resident F indicated, she didn't have her call button near her when she fell on 12/8/21. She stated, she was attempting to go too the bathroom in the middle of the night when she slid down and hit her head on the floor. She tried to scoot herself to the bathroom where the handle bars were but it was too high to reach and so she scooted her self back by the bedroom. She stated, she finally heard people in the hallway that evening and so she yelled as loud as she could and finally someone came in to help her. She further stated, "There is no guarantee when someone is going to come to your room when you put your call light on. I do my own medications so no one comes into my room and no one checks on you." A Fall Prevention and Management policy was received from DON on 1/5/22 at 10:43 a.m. It indicated, "Procedure: A. All residents are assessed for risk of falls on			

	admission, with ongoing assessments occurring on a routine basis, and upon any significant change in resident condition. This information shall be included in the resident's medical record...C. Upon a resident fall event, an immediate assessment... and/or evaluation...The licensed nurse at the Community shall be promptly notified and consulted as appropriate...E. The resident's primary care provider shall be notified of any fall event. Any communication with the primary care provider along with any orders received shall be documented in the resident's medical record...G. The resident's representative or primary emergency contact shall be notified of fall event unless otherwise stated or requested by the resident. If the resident refuses notification of their representative or primary emergency contact, this shall be included in the medical record...H. An incident report shall be completed..." An Incident Report policy was received from DON on 1/5/22 at 3:30 p.m. It indicated, "Procedure:...9. Record the name, date, and time the attending physician was notified. 10. Record the name, date, and time a responsible party was notified, if applicable. If the resident refuses notification of the responsible party, document			

this as "refused responsible party notification' and have resident sign near this documentation...Resident Related Incidents...2. Update the Resident's Service Plan to address fall prevention."

This state residential finding relates to IN00369700.

Based on interview and record review, the facility failed to implement the incident policy and the fall prevention and management policy for 3 of 4 residents reviewed for falls. (Residents B, D, and F)

Findings include:

1. A nursing note dated 12/7/21 at 9:15 p.m. indicated, "Resident had unwitnessed fall. she was found on the floor in her room. Stated to the writer, she stepped on her rob[sic] while backing out from the bathroom...Unable to contact family. Phone not responding..."

The incident/accident report was undated with a time of incident of 7:30 p.m. and contained a description of a fall that was related to the nursing note. The report did not indicate the emergency contact was notified as the section was left blank.

A nursing note dated 12/12/21 at 10:37 a.m. indicated, "Nurse received resident on the floor in her room at approximately

	10am[sic], resident states she fell in the middle of the night but couldn't find her call bell to notify staff. An interview with Resident B was conducted on 1/7/22 at 11:27 a.m. Resident B indicated, on 12/12/21, "I was trying to get up to go to the bathroom and I remember it was dark outside. I think it was about 2 a.m. and I didn't have on the non slip socks and I slid down and hit my right upper arm/shoulder area and hit my head on the floor. The nurse in the morning came in to give me my medicine and that is how they found me. My call light button was not near me and honestly, I'm not even sure help would have come." An interview with Resident B's daughter was conducted on 1/7/22 at 11:20 a.m. She indicated, she had not been notified of either the 12/7/21 fall nor the 12/12/21 fall. An interview with DON (Director of Nursing) was conducted on 1/6/22 at 9:51 a.m. indicated, she was unable to locate an incident/accident report for Resident B's 12/12/21 fall. 2. The clinical record for Resident D was reviewed on 1/5/22 at 10:56 a.m. Resident D's diagnoses included, but not limited to, major depressive			

disorder, history of falling, muscle weakness, and emphysema.

A nursing note dated 12/15/21 at 7:03 a.m. indicated, Resident B was found sitting on the floor in her room. She stated she had fallen on her way to the bathroom and hit the back of her head on the bed resulting in an open area the back of her right arm.

The incident/accident report for Resident D dated 12/15/21 was received from DON (Director of Nursing) on 1/5/21 at 2:21 p.m. The incident/accident form did not indicate Resident D's physician had been notified of her fall as that section of the form was blank.

A nursing note dated 12/29/21 at 9:41 a.m. indicated, Resident D was found on the floor next to her recliner chair and was unable to stand. The nurse called 911 for assistance with getting Resident D up. Resident D refused to go to the emergency room for follow up.

The incident/accident report for Resident D's fall on 12/29/21 did not indicate her emergency contact was notified of her fall as that section of the form stated "unable to locate".

An incident/accident report dated 1/1/22 indicated Resident D had a fall at 12:30 p.m. It

	stated, "Resident states, getting ice, lost balance, grabbed the freezer door and the 'whole thing' came down. 911 called to transfer to [sic, local hospital]". The incident form did not indicate her emergency contact was notified of her fall as that section of the form stated, "unable to find". 3. An incident/accident report dated 12/8/21 for Resident F was received from DON on 1/5/22 at 2:21 p.m. It indicated, "Resident was found on the floor laying[sic] with pillow under her head. Alert and oriented x 3. Resident stated to the writer that she fell since [sic] midnight while going to the bathroom..." The incident report did not indicate Resident F's physician was notified of her fall as that section of the form stated, "n/a" [sic, not applicable]. A review of Resident F's clinical record was conducted on 1/6/21 at 9:41 a.m. Resident F's clinical record did not contain a fall risk assessment. An interview with Resident F was conducted on 1/7/22 at 10:23 a.m. Resident F indicated, she didn't have her call button near her when she fell on 12/8/21. She stated, she was attempting to go too the bathroom in the middle of the night when she slid down and hit her head on the floor. She			

	tried to scoot herself to the bathroom where the handle bars were but it was too high to reach and so she scooted her self back by the bedroom. She stated, she finally heard people in the hallway that evening and so she yelled as loud as she could and finally someone came in to help her. She further stated, "There is no guarantee when someone is going to come to your room when you put your call light on. I do my own medications so no one comes into my room and no one checks on you." A Fall Prevention and Management policy was received from DON on 1/5/22 at 10:43 a.m. It indicated, "Procedure: A. All residents are assessed for risk of falls on admission, with ongoing assessments occurring on a routine basis, and upon any significant change in resident condition. This information shall be included in the resident's medical record...C. Upon a resident fall event, an immediate assessment... and/or evaluation...The licensed nurse at the Community shall be promptly notified and consulted as appropriate...E. The resident's primary care provider shall be notified of any fall event. Any communication with the primary care provider along with any orders received shall be documented in the resident's			

	medical record...G. The resident's representative or primary emergency contact shall be notified of fall event unless otherwise stated or requested by the resident. If the resident refuses notification of their representative or primary emergency contact, this shall be included in the medical record...H. An incident report shall be completed..." An Incident Report policy was received from DON on 1/5/22 at 3:30 p.m. It indicated, "Procedure:...9. Record the name, date, and time the attending physician was notified. 10. Record the name, date, and time a responsible party was notified, if applicable. If the resident refuses notification of the responsible party, document this as "refused responsible party notification' and have resident sign near this documentation...Resident Related Incidents...2. Update the Resident's Service Plan to address fall prevention." This state residential finding relates to IN00369700.			
R 0269	Food and Nutritional Services - Noncompliance 410 IAC 16.2-5-5.1(b) (b) The menu or substitutions, or both, for all meals shall be approved by a registered dietician.	R 0269	R269 -**What corrective action(s) will be accomplished for those residents found to have been**	01/24/2022

	Based on interview and record review, the facility failed to ensure menu substitutions were approved by a registered dietician for the residents that reside at the facility. (110 residents) Findings include: An observation of the lunch meal service was made on 1/7/22 at 12:27 p.m. The lunch meal consisted of fried cod plank, two pieces of bread, and French fries with an optional side salad. The alternate meal choice was a salad with chicken on top. A copy of the Fall/Winter menu was provided on 1/5/22. The menu indicated, for Friday, January 7, 2022, the lunch meal planned was Salisbury beef steak, mashed potatoes, steamed broccoli, fresh baked bread, brownie, and margarine. The alternate menu item was Mandarin orange chicken salad. An interview with DD (Dietary Director) was conducted on 1/7/22 at 3 p.m. DD indicated, the dietary menus are created by Gardant Solutions and are approved by the consult Dietician. He stated, any substitutions to the daily menu are made by him on a daily basis as he only meets with the corporate Dietician twice a		**affected by the deficient practice?** Menu substitutions will be reviewed and approved by the dietician moving forward. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents were affected by this deficient practice. Menu substitutions will be reviewed and approved by the dietician moving forward. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	

	month. DD indicated, he had to make substitutions to today's lunch menu because their food delivery company canceled his order for Salisbury steaks due to unavailability. When asked if the substitutions were approved by a Dietician, he stated, "no, but I made appropriate substitutions." An interview with CD (Consult Dietician) was conducted on 1/7/22 at 3:25 p.m. CD indicated, she had emailed DD the substitution menu guide and had provided training on appropriate substitutions because the facility was "having issues with having a lot of substitutions and the residents were not happy". When asked if the substitutions made to today's lunch were appropriate, she indicated, eliminating the steamed broccoli and not replacing it with another vegetable high in vitamin A may not provide enough vitamin A for the day. She stated, the substitutions to today's menu were not discussed with her prior. A copy of the Guide to Menu Substitutions was provided by CD on 1/7/22 at 3:41 p.m. It indicated, "Please be aware that making changes on your menu, whether just a one-time substitution or a permanent menu change, requires approval from your Registered Dietitian (RD). It is highly suggested that		The dietary manager will communicate all menu changes at least the day before the meal is to be served to the Admin and/or the dietician to ensure the menu is approved. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur,** **i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the**	

	the Dining Services Manager discuss with the RD the policy and procedure for how meal substitutes and menu changes are to be handled and documented...If you are unsure what constitutes a nutritionally equivalent substitute for an item, please contact your Registered Dietitian or Dining RD. A log of substitutions must be kept on file, including what food item(s) was/were substituted, the date, reason for the substitution(s) and what new food item(s) was/were served. This log must be reviewed and signed off by the Consultant Dietitian regularly." Based on interview and record review, the facility failed to ensure menu substitutions were approved by a registered dietician for the residents that reside at the facility. (110 residents) Findings include: An observation of the lunch meal service was made on 1/7/22 at 12:27 p.m. The lunch meal consisted of fried cod plank, two pieces of bread, and French fries with an optional side salad. The alternate meal choice was a salad with chicken on top. A copy of the Fall/Winter menu was provided on 1/5/22. The menu indicated, for Friday,		**systematic changes will be completed** January 24, 2022	

	January 7, 2022, the lunch meal planned was Salisbury beef steak, mashed potatoes, steamed broccoli, fresh baked bread, brownie, and margarine. The alternate menu item was Mandarin orange chicken salad. An interview with DD (Dietary Director) was conducted on 1/7/22 at 3 p.m. DD indicated, the dietary menus are created by Gardant Solutions and are approved by the consult Dietician. He stated, any substitutions to the daily menu are made by him on a daily basis as he only meets with the corporate Dietician twice a month. DD indicated, he had to make substitutions to today's lunch menu because their food delivery company canceled his order for Salisbury steaks due to unavailability. When asked if the substitutions were approved by a Dietician, he stated, "no, but I made appropriate substitutions." An interview with CD (Consult Dietician) was conducted on 1/7/22 at 3:25 p.m. CD indicated, she had emailed DD the substitution menu guide and had provided training on appropriate substitutions because the facility was "having issues with having a lot of substitutions and the residents were not happy". When asked if the substitutions made to today's lunch were appropriate, she indicated, eliminating the			

	steamed broccoli and not replacing it with another vegetable high in vitamin A may not provide enough vitamin A for the day. She stated, the substitutions to today's menu were not discussed with her prior. A copy of the Guide to Menu Substitutions was provided by CD on 1/7/22 at 3:41 p.m. It indicated, "Please be aware that making changes on your menu, whether just a one-time substitution or a permanent menu change, requires approval from your Registered Dietitian (RD). It is highly suggested that the Dining Services Manager discuss with the RD the policy and procedure for how meal substitutes and menu changes are to be handled and documented...If you are unsure what constitutes a nutritionally equivalent substitute for an item, please contact your Registered Dietitian or Dining RD. A log of substitutions must be kept on file, including what food item(s) was/were substituted, the date, reason for the substitution(s) and what new food item(s) was/were served. This log must be reviewed and signed off by the Consultant Dietitian regularly."			
R 0270	Food and Nutritional Services - Deficiency	R 0270	R270	01/24/2022

	410 IAC 16.2-5-5.1(c)(1-3) (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on interview and record review, the facility failed to meet the temporary need for meals to be delivered to a resident's room who was in isolation related to COVID for 1 of 5 residents reviewed for infection prevention. (Resident C) Findings include: An interview was conducted with Resident C on 1/5/22 at 2:56 p.m. Resident C indicated, she had tested positive for COVID-19 on 12/6/21 by the facility. She went to the hospital and was admitted for COVID and pneumonia secondary to COVID-19. She was discharged from the hospital on the 12/10/21 and returned to the facility on 12/14/21 and was placed in quarantine for 14 days. She stated, the day after she returned to the facility she was not given breakfast or dinner. She indicated, by the afternoon on the 15th of December, she was so hungry		-**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C was confirmed to be on the room tray list and will receive all her meals in her room until she is no longer on rooms trays and will be notified of the change. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.**	

	that she walked out of her room and yelled out to a staff member who walked by that she was hungry and hadn't received breakfast that morning. She stated, the staff member returned with a sandwich for her. An interview with Resident C's daughter was conducted on 1/5/21 at 4 p.m. Resident C's daughter indicated, on 12/15/21 at 5: 50 p.m. she was talking to her mother on the phone and had told her mom to put on her call light to remind staff to bring her dinner. She stated, she spoke with her mom until about 7 p.m. and by the time she hung up with her mom, no one had delivered her mom's dinner or answered the call light. An interview with DD (Dietary Director) was conducted on 1/5/22 at 11:15 a.m. DM indicated, previous to the current DON (Director of Nursing), the method they used to identify residents who needed their meals delivered to their rooms was a dry erase board. He stated, the CNAs (Certified Nursing Assistants) would come into the kitchen and write or erase resident names on the board all the time and sometimes residents could get missed. He indicated, the dry erase board is no longer being used because of the past issues and now the DON is the only		Any resident who is on room trays had the potential to be affected by this deficient practice. The room tray list was reviewed and confirmed by the DON/Designee on Jan. 7, 2022. All residents who are to receive room trays will have their meals delivered to their rooms until they are removed from the room tray list. DON to update this list as needed and communicate changes to nursing staff and dietary staff. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The room tray list will be reviewed and confirmed by the DON/Designee weekly. All residents who are to receive room trays will have their meals delivered to their rooms until they are removed from the room tray list. DON to update this list as needed and communicate changes to nursing staff and dietary staff. -**How the corrective action(s) will be monitored to**	

	person who creates or changes the meal delivery list. He stated, the CNAs are responsible for the delivery of the meals to the residents and "has no idea what happens to the food after it leaves the kitchen". The Service Plan dated 3/28/21 for Resident C was received on 1/7/22 at 4:28 p.m. from DON. It indicated, a need for Resident C was related to COVID-19 and stated, "will have room trays delivered to room as needed if displaying symptoms". Objectives included, but not limited to, "meals will be provided". This state residential finding relates to complaint IN00369332. Based on interview and record review, the facility failed to meet the temporary need for meals to be delivered to a resident's room who was in isolation related to COVID for 1 of 5 residents reviewed for infection prevention. (Resident C) Findings include: An interview was conducted with Resident C on 1/5/22 at 2:56 p.m. Resident C indicated, she had tested positive for COVID-19 on 12/6/21 by the facility. She went to the hospital and was admitted for COVID and pneumonia secondary to COVID-19. She was discharged		**ensure the deficient practice will not recur,** **i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** January 24, 2022	

	from the hospital on the 12/10/21 and returned to the facility on 12/14/21 and was placed in quarantine for 14 days. She stated, the day after she returned to the facility she was not given breakfast or dinner. She indicated, by the afternoon on the 15th of December, she was so hungry that she walked out of her room and yelled out to a staff member who walked by that she was hungry and hadn't received breakfast that morning. She stated, the staff member returned with a sandwich for her. An interview with Resident C's daughter was conducted on 1/5/21 at 4 p.m. Resident C's daughter indicated, on 12/15/21 at 5: 50 p.m. she was talking to her mother on the phone and had told her mom to put on her call light to remind staff to bring her dinner. She stated, she spoke with her mom until about 7 p.m. and by the time she hung up with her mom, no one had delivered her mom's dinner or answered the call light. An interview with DD (Dietary Director) was conducted on 1/5/22 at 11:15 a.m. DM indicated, previous to the current DON (Director of Nursing), the method they used to identify residents who needed their meals delivered to their rooms was a dry erase board.			

	He stated, the CNAs (Certified Nursing Assistants) would come into the kitchen and write or erase resident names on the board all the time and sometimes residents could get missed. He indicated, the dry erase board is no longer being used because of the past issues and now the DON is the only person who creates or changes the meal delivery list. He stated, the CNAs are responsible for the delivery of the meals to the residents and "has no idea what happens to the food after it leaves the kitchen". The Service Plan dated 3/28/21 for Resident C was received on 1/7/22 at 4:28 p.m. from DON. It indicated, a need for Resident C was related to COVID-19 and stated, "will have room trays delivered to room as needed if displaying symptoms". Objectives included, but not limited to, "meals will be provided". This state residential finding relates to complaint IN00369332.			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:	R 0356	R356 -**What corrective action(s) will be accomplished for those residents found to have been affected**	01/24/2022

	(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the emergency information file for a resident contained the resident's hospital preference and the emergency contact information for 1 of 4 residents reviewed for falls. (Resident D) Findings include: The clinical record for Resident D was reviewed on 1/5/22 at 10:56 a.m. Resident D's clinical		**by the deficient practice?** Resident D emergency contact information was updated with the residents Physician name and number and listed -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by this deficient practice. The DON will complete an audit of resident's emergency contacts by 1/24/2022. Any findings will be corrected and updated. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	

	record contains an "Emergency Printout". The emergency printout contains the following information: a problem list/Diagnosis, allergies, preferred care locations, and current medications. The emergency printout did not contain Resident D's physician's name or phone number nor an emergency contact's name and phone number. An interview with DON was conducted on 1/7/22 at 10:57 a.m. DON indicated, when a resident is transferred out of the facility, the emergency printout is to be sent with the resident. A nursing note dated 12/15/21 at 7:03 a.m. indicated, "Resident was found sitting on the floor in her room stated that she fell on her back and hit her head on the bed when she was going to the bathroom. She has some open areas to the back of her right arm and refused to go to the hospital. Resident doesn't have emergency contact in her charting. I asked her who is her emergency contact [sic] she gave me the name and the phone number. Her name is [sic emergency contact's name] was notified..." Based on record review and interview, the facility failed to ensure the emergency information file for a resident contained the resident's hospital		An emergency contact binder will be made available with each resident's information. It will be updated as needed by the DON/designee. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be**	

	preference and the emergency contact information for 1 of 4 residents reviewed for falls. (Resident D) Findings include: The clinical record for Resident D was reviewed on 1/5/22 at 10:56 a.m. Resident D's clinical record contains an "Emergency Printout". The emergency printout contains the following information: a problem list/Diagnosis, allergies, preferred care locations, and current medications. The emergency printout did not contain Resident D's physician's name or phone number nor an emergency contact's name and phone number. An interview with DON was conducted on 1/7/22 at 10:57 a.m. DON indicated, when a resident is transferred out of the facility, the emergency printout is to be sent with the resident. A nursing note dated 12/15/21 at 7:03 a.m. indicated, "Resident was found sitting on the floor in her room stated that she fell on her back and hit her head on the bed when she was going to the bathroom. She has some open areas to the back of her right arm and refused to go to the hospital. Resident doesn't have emergency contact in her charting. I asked her who is her emergency contact [sic] she		**completed** January 24, 2022	

	gave me the name and the phone number. Her name is [sic emergency contact's name] was notified..."			
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, record review, and interview, the facility failed maintain an infection control practice to properly prevent and/or contain COVID-19 by not ensuring all residents and staff were tested for COVID during an outbreak for 110 out of 110 residents residing in the facility, not assessing residents for signs and symptoms of COVID daily, not retaining COVID testing results for staff and residents, not utilizing eye protection when within 6 feet of a resident, staff not wearing the appropriate type of mask, and not wearing wearing a facemask properly. Findings include: 1. a. An interview with ED (Executive Director) was conducted on 1/7/22 at 1:40 p.m. ED indicated, until	R 0406	R406 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Unvaccinated staff are tested twice a week, and this is documented. Outbreak testing occurs once a resident is identified to be COVID19 positive per policy, and this is documented. All staff will wear mask per policy in the community. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by	01/24/2022

	December 28, 2021, the facility had not had an outbreak of COVID since December 2020 in residents, but has had staff members test positive for COVID during that time frame. b. An interview with Resident C was conducted on 1/5/22 at 2:56 p.m. Resident C indicated, she was tested for COVID-19 on December 6, 2021 at the facility. She stated, she had not been feeling well for a few days prior to the facility testing her for COVID-19 and even told her friend that she couldn't eat because she was short of breath, had body aches, and was fatigued. A CNA (Certified Nursing Assistant) task note dated 12/6/21 at 7:44 a.m. indicated, "I can not go to her room because she was sick". An interview with Resident C's daughter was conducted on 1/5/22 at 3:50 p.m. Resident C's daughter indicated, she had been at the facility on 12/5/21 to visit her mom and at that time she noticed her mom had increased shortness of breath. She stated, her mom pushed her call light and when the staff member came to answer the call light, they asked to see a nurse for her shortness of breath, but a nurse never came to her mom's room. She indicated, her mom had told her		this deficient practice. Unvaccinated staff are tested twice a week, and this is documented. Outbreak testing occurs once a resident is identified to be COVID19 positive per policy, and this is documented. All staff were in serviced on 1/10/22 by DON, DM, and Admin, on infection control relating to the proper way to wear a mask. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** A COVID19 testing binder will be made available with each resident's and staff's information. It will be updated as needed after COVID testing occurs by the DON/designee. Weekly audits will be performed to check an ensure all staff and community members are wearing their masks appropriately. Re-education will be given as	

	that she had to raise the head of her bed up the night before to be able to breathe. On 12/6/21, she called her mom in the morning to see how her mom was doing and her mom stated she still wasn't feeling well and a nurse still had not been in. This is when Resident C's daughter decided to have her brother pick up their mom from the facility and take her to an emergency room. Resident C's hospitalization record was received at 9:07 a.m. on 1/7/22 from the hospital. It indicated, Resident C was hospitalized from 12/6/21 to 12/10/21 with COVID-19 and pneumonia. The facility failed to identify an outbreak of COVID on 12/6/21 and initiate outbreak testing for staff and residents.		needed. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed**	

	The CMS (Centers for Medicare and Medicaid)'s QSO-20-38-NH, last revised on 9/10/2021, indicated, "A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident triggers an outbreak investigation. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. A resident who is admitted to the facility with COVID-19 does not constitute a facility outbreak. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing." 2. An interview with DON (Director of Nursing) was conducted on 1/7/21 at 2:19 p.m. DON indicated, residents are not assessed daily for signs/symptoms of COVID. She stated, if residents are exhibiting symptoms of COVID or just not feeling well, they rely on the residents to inform staff and then they would test the resident for COVID. The CDC's (Center for Diseases and Control) Interim Infection Prevention and Control		January 24, 2022	

	Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes Nursing Homes & Long-Term Care Facilities, last updated Sept. 10, 2021, indicated, "Evaluate Residents at least Daily: - Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection. - Actively monitor all residents upon admission and at least daily for fever (temperature =100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement precautions described in Section: Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection" 3. An interview with DON was conducted on 1/7/21 at 2:19 p.m. She indicated, she was unable to provide COVID testing information/results for the residents. She stated, COVID testing information and the corresponding results should have been documented in the resident's clinical record. She further indicated, the facility was unable to provide staff COVID testing information/results as well.			

	A review of the clinical records for Residents B, C, D, E, and F was conducted on 1/5/21. None of the clinical records contained COVID testing information/results. The CDC's (Center for Diseases and Control) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes Nursing Homes & Long-Term Care Facilities, last updated Sept. 10, 2021, indicated, "Expanded screening testing of asymptomatic HCP should be as follows: -Fully vaccinated HCP may be exempt from expanded screening testing. In nursing homes, unvaccinated HCP should continue expanded screening testing based on the level of community transmission as follows: In nursing homes located in counties with substantial to high community transmission, unvaccinated HCP should have a viral test twice a week. If unvaccinated HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift)." 4. a. An observation was made on 1/5/22 at 2:27 p.m. of QMA (Qualified Medication Assistant) 3. QMA 3 and Resident G were in the doorway to the nursing			

	office. QMA 3 leaned down to speak into Resident G's ear. QMA 3 was not wearing a faceshield at the time and was within 6 feet of the resident. b. An observation was made on 1/5/22 at 2:33 p.m. of PT (Physical Therapist) 5. PT 5 was wheeling Resident H from the therapy department back to his room. PT 5 was not wearing a face shield and was within 6 feet of the resident. 5. a. An observation was made on 1/5/22 at 11:13 a.m. of UW (Universal Worker) 6 in the kitchen. UW 6 was scooping pudding into individual serving cups. UW 6 was wearing a cloth mask that was pulled down under her chin while performing the task. An interview with UW 6 was conducted immediately following the observation. UW 6 indicated, the surgical face masks make her "break out" and that is why she was wearing a cloth mask. She further stated, she could put a surgical mask over the cloth mask. The CDC's (Center for Diseases and Control) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic last updated, Sept. 10, 2021,			

	indicated, "Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel." b. An observation was made on 1/5/22 at 2:24 p.m. of LPN (Licensed Practical Nurse) 4. LPN 4 walked up to Resident G, who was in the doorway to the nursing office, pulled down her mask below her nose and mouth, leaned down, and hugged Resident G. Resident G's face mask was not covering her nose at the time. The CDC's (Center for Diseases and Control) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic last updated, Sept. 10, 2021, indicated, "Source control options for HCP include: - A NIOSH-approved N95 or equivalent or higher-level respirator OR - A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (note: these should not be used instead of a NIOSH-approved respirator when respiratory			

protection is indicated) OR

- A well-fitting facemask."

c. An observation was made during lunch service on 1/7/22 at 12:27 p.m. UW 7 was not wearing a face shield while serving residents their lunch meals.

The CDC's (Center for Diseases and Control) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic last updated, Sept. 10, 2021, indicated, "If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below:

· NIOSH-approved N95 or equivalent or higher-level respirators should be used for:
-All aerosol-generating procedures (refer to Which procedures are considered aerosol generating procedures in healthcare settings?)

-All surgical procedures that might pose higher risk for transmission if the patient has COVID-19 (e.g., that generate potentially infectious aerosols or involving anatomic regions

	where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract) · Facilities could consider use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP working in other situations where multiple risk factors for transmission are present. One example might be if the patient is unvaccinated, unable to use source control, and the area is poorly ventilated. · Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters." This state residential finding relates to complaint IN00369332. Based on observation, record review, and interview, the facility failed maintain an infection control practice to properly prevent and/or contain COVID-19 by not ensuring all residents and staff were tested for COVID during an outbreak for 110 out of 110 residents residing in the facility, not assessing residents for signs and symptoms of COVID daily, not retaining COVID testing results for staff and residents, not utilizing eye protection when within 6 feet of a resident, staff			

not wearing the appropriate type of mask, and not wearing wearing a facemask properly.

Findings include:

1. a. An interview with ED (Executive Director) was conducted on 1/7/22 at 1:40 p.m. ED indicated, until December 28, 2021, the facility had not had an outbreak of COVID since December 2020 in residents, but has had staff members test positive for COVID during that time frame.

b. An interview with Resident C was conducted on 1/5/22 at 2:56 p.m. Resident C indicated, she was tested for COVID-19 on December 6, 2021 at the facility. She stated, she had not been feeling well for a few days prior to the facility testing her for COVID-19 and even told her friend that she couldn't eat because she was short of breath, had body aches, and was fatigued.

A CNA (Certified Nursing Assistant) task note dated 12/6/21 at 7:44 a.m. indicated, "I can not go to her room because she was sick".

An interview with Resident C's daughter was conducted on 1/5/22 at 3:50 p.m. Resident C's daughter indicated, she had been at the facility on 12/5/21 to visit her mom and at that time she noticed her mom had

	increased shortness of breath. She stated, her mom pushed her call light and when the staff member came to answer the call light, they asked to see a nurse for her shortness of breath, but a nurse never came to her mom's room. She indicated, her mom had told her that she had to raise the head of her bed up the night before to be able to breathe. On 12/6/21, she called her mom in the morning to see how her mom was doing and her mom stated she still wasn't feeling well and a nurse still had not been in. This is when Resident C's daughter decided to have her brother pick up their mom from the facility and take her to an emergency room. Resident C's hospitalization record was received at 9:07 a.m. on 1/7/22 from the hospital. It indicated, Resident C was hospitalized from 12/6/21 to 12/10/21 with COVID-19 and pneumonia. The facility failed to identify an outbreak of COVID on 12/6/21 and initiate outbreak testing for staff and residents. The CMS (Centers for Medicare and Medicaid)'s QSO-20-38-NH, last revised on 9/10/2021, indicated, "A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident			

	triggers an outbreak investigation. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. A resident who is admitted to the facility with COVID-19 does not constitute a facility outbreak. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing." 2. An interview with DON (Director of Nursing) was conducted on 1/7/21 at 2:19 p.m. DON indicated, residents are not assessed daily for signs/symptoms of COVID. She stated, if residents are exhibiting symptoms of COVID or just not feeling well, they rely on the residents to inform staff and then they would test the resident for COVID.			

	The CDC's (Center for Diseases and Control) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes Nursing Homes & Long-Term Care Facilities, last updated Sept. 10, 2021, indicated, "Evaluate Residents at least Daily: - Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection. - Actively monitor all residents upon admission and at least daily for fever (temperature =100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement precautions described in Section: Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection" 3. An interview with DON was conducted on 1/7/21 at 2:19 p.m. She indicated, she was unable to provide COVID testing information/results for the residents. She stated, COVID testing information and the corresponding results should have been documented in the resident's clinical record. She further indicated, the facility was unable to provide staff COVID			

	testing information/results as well. A review of the clinical records for Residents B, C, D, E, and F was conducted on 1/5/21. None of the clinical records contained COVID testing information/results. The CDC's (Center for Diseases and Control) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes Nursing Homes & Long-Term Care Facilities, last updated Sept. 10, 2021, indicated, "Expanded screening testing of asymptomatic HCP should be as follows: -Fully vaccinated HCP may be exempt from expanded screening testing. In nursing homes, unvaccinated HCP should continue expanded screening testing based on the level of community transmission as follows: In nursing homes located in counties with substantial to high community transmission, unvaccinated HCP should have a viral test twice a week. If unvaccinated HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift)." 4. a. An observation was made on 1/5/22 at 2:27 p.m. of QMA			

	(Qualified Medication Assistant) 3. QMA 3 and Resident G were in the doorway to the nursing office. QMA 3 leaned down to speak into Resident G's ear. QMA 3 was not wearing a faceshield at the time and was within 6 feet of the resident. b. An observation was made on 1/5/22 at 2:33 p.m. of PT (Physical Therapist) 5. PT 5 was wheeling Resident H from the therapy department back to his room. PT 5 was not wearing a face shield and was within 6 feet of the resident. 5. a. An observation was made on 1/5/22 at 11:13 a.m. of UW (Universal Worker) 6 in the kitchen. UW 6 was scooping pudding into individual serving cups. UW 6 was wearing a cloth mask that was pulled down under her chin while performing the task. An interview with UW 6 was conducted immediately following the observation. UW 6 indicated, the surgical face masks make her "break out" and that is why she was wearing a cloth mask. She further stated, she could put a surgical mask over the cloth mask. The CDC's (Center for Diseases and Control) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During			

	the Coronavirus Disease 2019 (COVID-19) Pandemic last updated, Sept. 10, 2021, indicated, "Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel." b. An observation was made on 1/5/22 at 2:24 p.m. of LPN (Licensed Practical Nurse) 4. LPN 4 walked up to Resident G, who was in the doorway to the nursing office, pulled down her mask below her nose and mouth, leaned down, and hugged Resident G. Resident G's face mask was not covering her nose at the time. The CDC's (Center for Diseases and Control) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic last updated, Sept. 10, 2021, indicated, "Source control options for HCP include: - A NIOSH-approved N95 or equivalent or higher-level respirator OR - A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (note:			

these should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) OR

- A well-fitting facemask."

c. An observation was made during lunch service on 1/7/22 at 12:27 p.m. UW 7 was not wearing a face shield while serving residents their lunch meals.

The CDC's (Center for Diseases and Control) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic last updated, Sept. 10, 2021, indicated, "If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below:

· NIOSH-approved N95 or equivalent or higher-level respirators should be used for:
-All aerosol-generating procedures (refer to Which procedures are considered aerosol generating procedures in healthcare settings?)

-All surgical procedures that might pose higher risk for transmission if the patient has

	COVID-19 (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract) · Facilities could consider use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP working in other situations where multiple risk factors for transmission are present. One example might be if the patient is unvaccinated, unable to use source control, and the area is poorly ventilated. · Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters." This state residential finding relates to complaint IN00369332.			
R 0413	Infection Control - Deficiency 410 IAC 16.2-5-12(j) (j) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident only to the degree needed to isolate the infecting organism. Based on interview and record	R 0413	R413 -**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	01/24/2022

	review, the facility failed to ensure a resident was placed in isolation precautions only to the the degree needed to isolate the infecting organism for 1 of 5 residents reviewed for infection control. (Resident C) Findings include: An interview with Resident C was conducted on 1/5/22 at 2:56 p.m. Resident C indicated, she tested positive for COVID-19 on December 6, 2021. She stated, she had not been feeling well for a few days prior to the facility testing her for COVID-19 and even told her friend that she couldn't eat because she was short of breath, had body aches, and was fatigued. An interview with Resident C's daughter was conducted on 1/5/22 at 3:50 p.m. Resident C's daughter indicated, she had been at the facility on 12/5/21 to visit her mom and at that time she noticed her mom had increased shortness of breath. She stated, her mom pushed her call light and when the staff member came to answer the call light, they asked to see a nurse for her shortness of breath, but a nurse never came to her mom's room. She indicated, her mom had told her that she had to raise the head of her bed up the night before to be able to breathe. On 12/6/21,		Resident C was no longer in isolation -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Any COVID19 positive resident have the potential to be affected by this deficient practice. Any resident currently in isolation was reviewed for isolation times and guidelines and no other concerns were found. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** A COVID19 testing binder will be made available with each resident’s and staff’s information. Isolation start and end times will be documented and reviewed in the binder by DON/designee weekly. It will be updated as needed after COVID testing occurs by	

	she called her mom in the morning to see how her mom was doing and her mom stated she still wasn't feeling well and a nurse still had not been in. This is when Resident C's daughter decided to have her brother pick up mom from the facility and take her to an emergency room. Resident C's hospitalization record was received at 9:07 a.m. on 1/7/22 from the hospital. It indicated, Resident C was hospitalized from 12/6/21 to 12/10/21 with COVID-19 and pneumonia. A nursing note dated 12/13/21 at 2:17 p.m. indicated, the facility spoke with Resident C's daughter and explained that upon Resident C's return to the facility, she will have to be quarantined for 14 days. A nursing note dated 12/14/21 at 9:20 p.m. indicated, Resident C returned to the facility. Resident C remained in quarantine for an additional 14 days upon returning to the facility. Resident C only needed to be quarantined for 10 days after her first positive COVID-19 test. The Centers for Diseases and Control's (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During		the DON/designee. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed**	

	the Coronavirus Disease 2019 (COVID-19) Pandemic last updated Sept. 10, 2021 indicated, "A symptom-based strategy for discontinuing Transmission-Based Precautions is preferred in most clinical situations. The criteria for the symptom-based strategy are: Patients with mild to moderate illness who are not moderately to severely immunocompromised: · At least 10 days have passed since symptoms first appeared and · At least 24 hours have passed since last fever without the use of fever-reducing medications and · Symptoms (e.g., cough, shortness of breath) have improved Patients who were asymptomatic throughout their infection and are not moderately to severely immunocompromised: · At least 10 days have passed since the date of their first positive viral diagnostic test." This state residential finding relates to complaint IN00369332. Based on interview and record		January 24, 2022	

review, the facility failed to ensure a resident was placed in isolation precautions only to the the degree needed to isolate the infecting organism for 1 of 5 residents reviewed for infection control. (Resident C)

Findings include:

An interview with Resident C was conducted on 1/5/22 at 2:56 p.m. Resident C indicated, she tested positive for COVID-19 on December 6, 2021. She stated, she had not been feeling well for a few days prior to the facility testing her for COVID-19 and even told her friend that she couldn't eat because she was short of breath, had body aches, and was fatigued.

An interview with Resident C's daughter was conducted on 1/5/22 at 3:50 p.m. Resident C's daughter indicated, she had been at the facility on 12/5/21 to visit her mom and at that time she noticed her mom had increased shortness of breath. She stated, her mom pushed her call light and when the staff member came to answer the call light, they asked to see a nurse for her shortness of breath, but a nurse never came to her mom's room. She indicated, her mom had told her that she had to raise the head of her bed up the night before to be able to breathe. On 12/6/21,

she called her mom in the morning to see how her mom was doing and her mom stated she still wasn't feeling well and a nurse still had not been in. This is when Resident C's daughter decided to have her brother pick up mom from the facility and take her to an emergency room.

Resident C's hospitalization record was received at 9:07 a.m. on 1/7/22 from the hospital. It indicated, Resident C was hospitalized from 12/6/21 to 12/10/21 with COVID-19 and pneumonia.

A nursing note dated 12/13/21 at 2:17 p.m. indicated, the facility spoke with Resident C's daughter and explained that upon Resident C's return to the facility, she will have to be quarantined for 14 days.

A nursing note dated 12/14/21 at 9:20 p.m. indicated, Resident C returned to the facility. Resident C remained in quarantine for an additional 14 days upon returning to the facility. Resident C only needed to be quarantined for 10 days after her first positive COVID-19 test.

The Centers for Diseases and Control's (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During

the Coronavirus Disease 2019 (COVID-19) Pandemic last updated Sept. 10, 2021 indicated, "A symptom-based strategy for discontinuing Transmission-Based Precautions is preferred in most clinical situations. The criteria for the symptom-based strategy are:

Patients with mild to moderate illness who are not moderately to severely immunocompromised:

· At least 10 days have passed since symptoms first appeared and

· At least 24 hours have passed since last fever without the use of fever-reducing medications and

· Symptoms (e.g., cough, shortness of breath) have improved

Patients who were asymptomatic throughout their infection and are not moderately to severely immunocompromised:

· At least 10 days have passed since the date of their first positive viral diagnostic test."

This state residential finding relates to complaint IN00369332.

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