STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF DYER	1763 CALUMET AVENUE, DYER, , 46311

(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 a Post Survey Revisit (PSR) to the Residential COVID-19 Quality Assurance Walk Through completed on December 1, 2021. This visit was in conjunction with the Investigation of Complaint IN00369671 and a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00369671 - Substantiated. State deficiencies related to the allegations are cited at R0406. Survey date: January 10, 2022 Facility number: 014415 Residential Census: 77 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/14/22.	R 0000		

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 to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to staff not wearing eye protection and/or incorrect eye protection when residents were present, wearing gloves in the hallway, no hand hygiene before and after glove removal, donning PPE(personal protective equipment) incorrectly, recapping a used insulin needle, incorrect disposal of an used lancet, and not monitoring residents who were in TBP for COVID-19 and/or daily monitoring for COVID-19 for 3 of 3 residents reviewed for infection control. This had the potential to affect all 77 residents who resided in the facility. (Residents B, C, and D) Findings include: 1. During a random observation on 1/10/22 at 8:50 a.m., Activity Aide 1 was observed in the	R 0406	**R 460** **Infection Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Staff will wear the appropriate facemask at all times in addition to a face shield while within 6ft of a resident. Increased respiratory assessments will be implemented for those residents with suspected/confirmed Covid-19. Vitals will be recorded daily per policy. **How**	02/10/2022

	activity room without her face mask on, the Activity Director was in the room as well. Interview with the Activity Aide at that time, indicated she was unaware her face mask must remain on at all times even around other healthcare professionals due to the high transmission rate of COVID-19. 2. During a random observation on 1/10/22 at 8:51 a.m., CNA 3 was observed in the dining room. At that time, there were many residents seated at tables waiting for breakfast. The CNA was wearing a KN95 face mask and a pair of safety glasses over her eyes. The glasses were not snug around her face and eyes and gaps were noted on the sides. CNA 2 was observed in the dining room as well. She was not wearing any eye protection. Dietary Aide 1 was observed walking out of the kitchen wearing a face mask and no eye protection. He walked up to several tables and was within 6 feet of the residents and took their breakfast orders. Interview with CNA 2 and CNA 3 at that time, indicated they were aware they needed to wear eye protection when residents were present. CNA 3 indicated she had thought her safety glasses were okay. CNA 2 indicated she had just arrived		**the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All Residents have the potential to be affected by the same deficient practice. To ensure residents are being properly monitored, the community will continue taking all residents vitals daily and will increase taking resident vitals to 3 times daily for any residents with suspected or confirmed Covid-19. Any abnormal vitals will be brought to the attention of the DOW and/or ED. All residents and staff will be PCR tested for Covid-19 twice weekly until community is free of outbreak status and/or county positivity rate decreases below 10%. All	

	at work and did not have a face shield on. 3. During a random observation on 1/10/22 at 8:53 a.m., LPN 1 was observed at the medication cart in the dining room. He was wearing an N95 face mask and a face shield. The face shield was completely open at the top with a large gap and his entire hand could go down through and touch his eyes and face. 4. During a random observation on 1/10/22 at 8:55 a.m., Activity Aide 1 observed talking to a resident with her face mask on. She was within 6 feet of another resident, however, she was not wearing any eye protection. The resident was also not wearing a face mask. At 8:57 a.m., the Activity Aide was observed wearing a pair of safety glasses over her eyes. The glasses were not snug or fitted to her face and had gaps on the sides and bottom. She was observed talking to more residents as they passed the activity room. There were 5 residents in the activity room all within 6 feet of the Activity Aide and she was observed wearing a KN95 face mask and a pair of safety glasses.		staff will continue screening with Concierge/Manager/Nurse on duty upon arrival. All overnight staff will be screened by Med Tech/Nurse on duty. Staff are not self-screening themselves. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** All staff are being educated and in-serviced on: The appropriate eye protection, PPE: donning and doffing (sequences), Infection control: Cross Contamination, and Glove and Hand Washing Policy & Procedure. Additionally, Nurses and QMAs are being educated and in-serviced on Glucose Monitoring Protocol, proper handling and disposal of needles and other sharps, as well as Infection control-Bloodborne Disease Prevention Policy &	

	Interview with Activity Aide 1 on 1/10/22 at 9:00 a.m., indicated she was not aware the safety glasses she was wearing were not approved for COVID-19. Interview with the Director of Wellness on 1/10/22 at 1:12 p.m., indicated all staff were to have the correct eye protection such as face shields or goggles when residents were present. The current and updated 11/22/21 "COVID-19 Infection Control Guidance in Long-term Care Facilities" policy, indicated "Continue universal source controls with well-fitting face mask use by all healthcare professionals (medical grade). Fully vaccinated HCP must continue to wear a mask while indoors. All healthcare professionals must wear eye protection for resident care when community transmission is substantial or high. Eye protection should be close to face with no gaps at top, bottom, or sides of eyes." 5. On 1/10/22 at 9:25 a.m. on the Memory Care Unit, there were 10 rooms with Red Stop Signs on the outside of the door, all indicating those residents were positive for COVID-19. At 9:30 a.m., CNA 1 was observed walking down the hallway with a basket of clean linen, wearing gloves to both hands. She walked to Resident		Procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DOW/Designee will audit 10 resident's vitals weekly for 3 months to ensure increased monitoring of vitals is taking place for all residents with suspected/confirmed Covid-19. The ED/Designee will conduct rounds twice daily to ensure proper PPE is in place and being worn properly. The RCM/Concierge will utilize resident and employee rosters to confirm twice weekly testing is taking place. The	

	B's room and doffed the gloves and threw them away. She removed an isolation gown and opened all the drawers in the 3 tiered bins looking for more gloves. She placed the gown on top of the bin and walked over to the sink in the dining area and removed a handful of gloves and walked over to the resident's room. There was a Red Stop Sign on the outside of the door and signage which indicated to enter the room, staff must wear a gown, gloves, face mask and face shield. The CNA donned a clean isolation gown and clean gloves to both hands. She did not perform hand hygiene. She removed her face mask and face shield and donned a new N95 face mask and a new face shield, with the same gloved hands. The CNA entered the resident's room and took the clean laundry in with her. At 9:44 a.m., CNA 1 opened the door, she removed her N95 face mask with her bare hands and walked out of the room. She donned a pair of clean gloves to both hands without performing hand hygiene and placed her old face mask and face shield back on. The CNA kept the gloves on both hands and picked up the laundry basket and walked down the hall. Interview with the Director of Wellness on 1/10/22 at 1:12 p.m., indicated CNA 1 was		Director of Wellness/Designee will present a summary of the audits to the Quality Excellence team monthly for 3 months. Thereafter, if determined by the Quality Excellence team, additional monitoring is required, audits will be done quarterly. Monitoring will be ongoing. **Date of Completion: February 10, 2022**	

aware she was not supposed to wear gloves in the hallway. Hand hygiene was to performed before donning and after glove removal and she should have donned the gloves last before entering the TBP room.

The current and undated "Glove and Hand Washing" policy, provided by the Director of Wellness (DOW) on 1/10/22 at 3:38 p.m., indicated hands were to washed before donning gloves and after removing gloves. Gloves were never placed on dirty hands, the procedure was always wash, glove, remove, rewash, and re-glove.

The current CDC guidance for "Sequence for putting on PPE" policy provided by the DOW on 1/10/22 at 3:38 p.m., indicated Gown, mask, goggles or face shield and gloves.

6. During a random observation on 1/10/22 at 9:45 a.m., Agency QMA 1 was observed wearing a face shield that was completely open at the top and had a large gap that a hand could go down it and touch the eyes and face. The QMA was observed in the dining room at that time, where there were 5 other residents all within 6 feet of her.

7. During an observation of a glucometer reading on 1/10/22 at 11:45 a.m., LPN 1 was

observed donning PPE to enter Resident C's room. There was a Red Stop Sign on the outside of the door and signage which indicated to enter the room, staff must wear a gown, gloves, face mask and face shield. The LPN was observed in full PPE and wearing the same face shield as before. He was standing by the resident's bed with the resident lying in the bed. The insulin pen, glucometer, alcohol wipes and lancet were laying directly on the bed next to the resident's head, on top of the resident's linens. After checking his blood sugar, he reached into his pocket with his gloved hands and pulled out the walkie talkie to contact Agency QMA 1 to see how much insulin the resident was supposed to receive. The QMA opened the door and told the LPN the resident was to receive 10 units of insulin. The LPN wiped the resident's abdomen and dialed the pen to 10 units and administered the insulin without priming the pen. He recapped the used insulin needle and walked towards the room door. He proceeded to doff his gown and gloves and threw them away with the used lancet inside the glove in the garbage can in the room. He walked out of the room with insulin pen and performed hand hygiene.

Interview with LPN 1 at that time, indicated he was unaware

his face shield was not acceptable. When asked about recapping the used insulin needle, LPN 1 stated "What do you want me to do with the needle, walk down the hall with it exposed? The sharps container was on the medication cart and there were none in the resident rooms." He was not aware he threw away the used lancet into the garbage can.

The medication cart with a sharps container was located in the nurses' station.

Interview with the Director of Wellness on 1/10/22 at 1:12 p.m., indicated LPN 1 should not have recapped the insulin pen needle or threw away the used lancet into the garbage can. He should not have set his clean supplies directly on the bed linens of the COVID-19 positive resident. She was not aware the face shield had a large gap in the front.

The current and undated "Infection Control-Bloodborne Disease Prevention" policy provided by the Director of Wellness on 1/10/22 at 3:38 p.m., indicated needles and syringes used by staff members to administer medication must be disposed of in an appropriately labeled puncture proof container. Needles should no be recapped.

8. Resident B's record was reviewed on 1/10/22 at 2:00 p.m.

Physician's Orders, dated 1/3/22, indicated the resident was to be in isolation for COVID-19.

Nurses' Notes, dated 1/3/22 at 10:34 p.m., indicated the resident tested positive to COVID-19.

Nurses' Notes, dated 1/4/22 at 4:58 a.m., by a QMA, indicated the resident remained in isolation and has a temperature 100.2. She was weak and shaking. Tylenol administered for temperature and no shortness of breath noted.

Nurses' Notes, dated 1/4/22 at 12:55 p.m., by the LPN, indicated the family was notified and updated on condition.

Nurses' Notes, dated 1/5/22 at 4:43 a.m., by a QMA, indicated the resident remained in isolation was weak with no fever or shortness of breath noted.

Nurses' Notes, dated 1/5/22 at 1:25 p.m., by the Director of Wellness (DOW) indicated the resident had fallen. An assessment of the resident was obtained and vital signs were checked.

Nurses' Notes, dated 1/6/22 at 4:46 a.m., by a QMA, indicated

the resident remained in isolation and was asymptomatic.

Nurses' Notes, dated 1/6/22 at 10:35 p.m., by a LPN, indicated the resident was resting in bed. No further falls noted. No injuries noted from previous fall. No signs and symptoms of pain or discomfort.

Nurses' Notes, dated 1/7/22 at 11:24 p.m., by a CNA, indicated the resident was roaming in the common area. Noticed her pants were wet and helped resident change into pajamas and put her in bed.

Nurses' Notes, dated 1/7/22 at 1:43 p.m., by a QMA, indicated a temperature of 97.8. No complaints or visible signs of discomfort or distress.

Nurses' Notes, dated 1/7/22 at 1:50 p.m., by a QMA, indicated the resident was chewing her meds. Meds may have to be crushed.

Nurses' Notes, dated 1/9/22 at 5:07 a.m., by a QMA, indicated the resident remained in isolation with no complaint of shortness of breath or fever.

Nurses' Notes, dated 1/9/22 at 10:34 a.m., by a QMA, indicated temperature of 98.2. No complaints.

Nurses' Notes, dated 1/10/22 at 4:31 a.m., by a QMA, indicated

resident remained in isolation with no complaint of shortness of breath or fever.

The vital signs section indicated a pulse, temperature, heart rate, blood pressure, and respirations were recorded on 1/3/22 at 8:33 a.m., and a pulse and temperature were recorded on 1/6/22 at 9:09 p.m.

There was no increased monitoring for the resident while positive for COVID-19.

9. The record for Resident C was reviewed on 1/10/22 at 1:03 p.m.

Nurses' Notes, dated 1/3/22 at 10:11 p.m., by a LPN indicated the resident tested positive to COVID -19. Isolation precautions observed.

Nurses' Notes, dated 1/4/22 at 8:16 p.m., by a QMA, indicated the resident was COVID positive.

Nurses' Notes, dated 1/5/22 at 4:32 a.m., by a QMA, indicated the resident remained in isolation and was asymptomatic with no fever or shortness breath noted.

Nurses' Notes, dated 1/6/22 at 4:40 a.m., by a QMA, indicated the resident remained in isolation and has had diarrhea times 2. Imodium given. No fever or shortness of breath.

Nurses' Notes, dated 1/7/22 at 1:31 p.m., by a QMA, indicated temperature 98.0. No complaints or visible issues.

Nurses' Notes, dated 1/9/22 at 5:05 a.m., by a QMA, indicated the resident remained in isolation with no complaints of shortness of breath or fever.

Nurses' Notes, dated 1/9/22 at 10:24 a.m., by a QMA, indicated temperature 98.6. No issues or complaints.

Nurses' Notes, dated 1/10/22 at 4:26 a.m., by a QMA, indicated the resident remained in isolation with no complaints of shortness of breath or fever.

The vital signs section indicated a full set of vital signs including temperature and pulse oximetry was taken on 1/6/22.

There was no increased monitoring for the resident while they their positive for COVID-19.

10. The record for Resident D was reviewed on 1/10/22 at 2:15 p.m.

The vital signs section indicated a temperature and pulse

	oximeter were documented on 1/2 and 1/3/22 for the month of January. There were no other vital signs including temperature and pulse oximeter recorded on a daily basis to monitor for signs and symptoms of COVID-19. Information received from the Director of Wellness indicated the facility was currently in outbreak status with 11 positive residents and 4 positive staff. Interview with the Director of Wellness on 1/10/22 at 1:12 p.m., indicated there was no documentation of daily COVID monitoring and increased monitoring for residents who currently have COVID. The facility only had a QMA working the midnight shift and they were not qualified to assess the resident's respiratory status. She was not able to find documentation of daily temperatures, vital signs, and pulse oximeter checks for the residents. The Indiana Department of Health current and updated 1/4/22 "Long-term Care COVID-19			

Clinical Guidance" policy indicated, "Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximeter.

· Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximeter, and respiratory exam, to at least three times daily to identify and quickly manage serious infection."

This State Residential Rule was cited on 12/1/21. The facility failed to implement a systemic plan of correction to prevent recurrence.

Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to staff not wearing eye protection and/or incorrect eye protection when residents were present, wearing gloves in the hallway, no hand hygiene before and after glove removal, donning PPE(personal protective equipment) incorrectly, recapping a used insulin needle, incorrect disposal of an used lancet, and not monitoring residents who were in TBP for COVID-19 and/or daily monitoring for

COVID-19 for 3 of 3 residents reviewed for infection control. This had the potential to affect all 77 residents who resided in the facility. (Residents B, C, and D)

Findings include:

1. During a random observation on 1/10/22 at 8:50 a.m., Activity Aide 1 was observed in the activity room without her face mask on, the Activity Director was in the room as well.

Interview with the Activity Aide at that time, indicated she was unaware her face mask must remain on at all times even around other healthcare professionals due to the high transmission rate of COVID-19.

2. During a random observation on 1/10/22 at 8:51 a.m., CNA 3 was observed in the dining room. At that time, there were many residents seated at tables waiting for breakfast. The CNA was wearing a KN95 face mask and a pair of safety glasses over her eyes. The glasses were not snug around her face and eyes and gaps were noted on the sides. CNA 2 was observed in the dining room as well. She was not wearing any eye protection. Dietary Aide 1 was observed walking out of the kitchen wearing a face mask and no eye protection. He walked up to several tables and

was within 6 feet of the residents and took their breakfast orders.

Interview with CNA 2 and CNA 3 at that time, indicated they were aware they needed to wear eye protection when residents were present. CNA 3 indicated she had thought her safety glasses were okay. CNA 2 indicated she had just arrived at work and did not have a face shield on.

3. During a random observation on 1/10/22 at 8:53 a.m., LPN 1 was observed at the medication cart in the dining room. He was wearing an N95 face mask and a face shield. The face shield was completely open at the top with a large gap and his entire hand could go down through and touch his eyes and face.

4. During a random observation on 1/10/22 at 8:55 a.m., Activity Aide 1 observed talking to a resident with her face mask on. She was within 6 feet of another resident, however, she was not wearing any eye protection. The resident was also not wearing a face mask. At 8:57 a.m., the Activity Aide was observed wearing a pair of safety glasses over her eyes. The glasses were not snug or fitted to her face and had gaps on the sides and bottom. She was observed talking to more residents as they passed the activity room. There

were 5 residents in the activity room all within 6 feet of the Activity Aide and she was observed wearing a KN95 face mask and a pair of safety glasses.

Interview with Activity Aide 1 on 1/10/22 at 9:00 a.m., indicated she was not aware the safety glasses she was wearing were not approved for COVID-19.

Interview with the Director of Wellness on 1/10/22 at 1:12 p.m., indicated all staff were to have the correct eye protection such as face shields or goggles when residents were present.

The current and updated 11/22/21 "COVID-19 Infection Control Guidance in Long-term Care Facilities" policy, indicated "Continue universal source controls with well-fitting face mask use by all healthcare professionals (medical grade). Fully vaccinated HCP must continue to wear a mask while indoors. All healthcare professionals must wear eye protection for resident care when community transmission is substantial or high. Eye protection should be close to face with no gaps at top, bottom, or sides of eyes."

5. On 1/10/22 at 9:25 a.m. on the Memory Care Unit, there were 10 rooms with Red Stop Signs on the outside of the

door, all indicating those residents were positive for COVID-19. At 9:30 a.m., CNA 1 was observed walking down the hallway with a basket of clean linen, wearing gloves to both hands. She walked to Resident B's room and doffed the gloves and threw them away. She removed an isolation gown and opened all the drawers in the 3 tiered bins looking for more gloves. She placed the gown on top of the bin and walked over to the sink in the dining area and removed a handful of gloves and walked over to the resident's room. There was a Red Stop Sign on the outside of the door and signage which indicated to enter the room, staff must wear a gown, gloves, face mask and face shield. The CNA donned a clean isolation gown and clean gloves to both hands. She did not perform hand hygiene. She removed her face mask and face shield and donned a new N95 face mask and a new face shield, with the same gloved hands. The CNA entered the resident's room and took the clean laundry in with her. At 9:44 a.m., CNA 1 opened the door, she removed her N95 face mask with her bare hands and walked out of the room. She donned a pair of clean gloves to both hands without performing hand hygiene and placed her old face mask and face shield back on. The CNA kept the gloves on

both hands and picked up the laundry basket and walked down the hall.

Interview with the Director of Wellness on 1/10/22 at 1:12 p.m., indicated CNA 1 was aware she was not supposed to wear gloves in the hallway. Hand hygiene was to performed before donning and after glove removal and she should have donned the gloves last before entering the TBP room.

The current and undated "Glove and Hand Washing" policy, provided by the Director of Wellness (DOW) on 1/10/22 at 3:38 p.m., indicated hands were to washed before donning gloves and after removing gloves. Gloves were never placed on dirty hands, the procedure was always wash, glove, remove, rewash, and re-glove.

The current CDC guidance for "Sequence for putting on PPE" policy provided by the DOW on 1/10/22 at 3:38 p.m., indicated Gown, mask, goggles or face shield and gloves.

6. During a random observation on 1/10/22 at 9:45 a.m., Agency QMA 1 was observed wearing a face shield that was completely open at the top and had a large gap that a hand could go down it and touch the eyes and face. The QMA was observed in the

dining room at that time, where there were 5 other residents all within 6 feet of her.

7. During an observation of a glucometer reading on 1/10/22 at 11:45 a.m., LPN 1 was observed donning PPE to enter Resident C's room. There was a Red Stop Sign on the outside of the door and signage which indicated to enter the room, staff must wear a gown, gloves, face mask and face shield. The LPN was observed in full PPE and wearing the same face shield as before. He was standing by the resident's bed with the resident lying in the bed. The insulin pen, glucometer, alcohol wipes and lancet were laying directly on the bed next to the resident's head, on top of the resident's linens. After checking his blood sugar, he reached into his pocket with his gloved hands and pulled out the walkie talkie to contact Agency QMA 1 to see how much insulin the resident was supposed to receive. The QMA opened the door and told the LPN the resident was to receive 10 units of insulin. The LPN wiped the resident's abdomen and dialed the pen to 10 units and administered the insulin without priming the pen. He recapped the used insulin needle and walked towards the room door. He proceeded to doff his gown and gloves and threw them away with the used lancet inside the glove in the

garbage can in the room. He walked out of the room with insulin pen and performed hand hygiene.

Interview with LPN 1 at that time, indicated he was unaware his face shield was not acceptable. When asked about recapping the used insulin needle, LPN 1 stated "What do you want me to do with the needle, walk down the hall with it exposed? The sharps container was on the medication cart and there were none in the resident rooms." He was not aware he threw away the used lancet into the garbage can.

The medication cart with a sharps container was located in the nurses' station.

Interview with the Director of Wellness on 1/10/22 at 1:12 p.m., indicated LPN 1 should not have recapped the insulin pen needle or threw away the used lancet into the garbage can. He should not have set his clean supplies directly on the bed linens of the COVID-19 positive resident. She was not aware the face shield had a large gap in the front.

The current and undated "Infection Control-Bloodborne Disease Prevention" policy provided by the Director of Wellness on 1/10/22 at 3:38 p.m., indicated needles and

syringes used by staff members to administer medication must be disposed of in an appropriately labeled puncture proof container. Needles should no be recapped.

8. Resident B's record was reviewed on 1/10/22 at 2:00 p.m.

Physician's Orders, dated 1/3/22, indicated the resident was to be in isolation for COVID-19.

Nurses' Notes, dated 1/3/22 at 10:34 p.m., indicated the resident tested positive to COVID-19.

Nurses' Notes, dated 1/4/22 at 4:58 a.m., by a QMA, indicated the resident remained in isolation and has a temperature 100.2. She was weak and shaking. Tylenol administered for temperature and no shortness of breath noted.

Nurses' Notes, dated 1/4/22 at 12:55 p.m., by the LPN, indicated the family was notified and updated on condition.

Nurses' Notes, dated 1/5/22 at 4:43 a.m., by a QMA, indicated the resident remained in isolation was weak with no fever or shortness of breath noted.

Nurses' Notes, dated 1/5/22 at 1:25 p.m., by the Director of Wellness (DOW) indicated the

resident had fallen. An assessment of the resident was obtained and vital signs were checked.

Nurses' Notes, dated 1/6/22 at 4:46 a.m., by a QMA, indicated the resident remained in isolation and was asymptomatic.

Nurses' Notes, dated 1/6/22 at 10:35 p.m., by a LPN, indicated the resident was resting in bed. No further falls noted. No injuries noted from previous fall. No signs and symptoms of pain or discomfort.

Nurses' Notes, dated 1/7/22 at 11:24 p.m., by a CNA, indicated the resident was roaming in the common area. Noticed her pants were wet and helped resident change into pajamas and put her in bed.

Nurses' Notes, dated 1/7/22 at 1:43 p.m., by a QMA, indicated a temperature of 97.8. No complaints or visible signs of discomfort or distress.

Nurses' Notes, dated 1/7/22 at 1:50 p.m., by a QMA, indicated the resident was chewing her meds. Meds may have to be crushed.

Nurses' Notes, dated 1/9/22 at 5:07 a.m., by a QMA, indicated the resident remained in isolation with no complaint of shortness of breath or fever.

Nurses' Notes, dated 1/9/22 at 10:34 a.m., by a QMA, indicated temperature of 98.2. No complaints.

Nurses' Notes, dated 1/10/22 at 4:31 a.m., by a QMA, indicated resident remained in isolation with no complaint of shortness of breath or fever.

The vital signs section indicated a pulse, temperature, heart rate, blood pressure, and respirations were recorded on 1/3/22 at 8:33 a.m., and a pulse and temperature were recorded on 1/6/22 at 9:09 p.m.

There was no increased monitoring for the resident while positive for COVID-19.

9. The record for Resident C was reviewed on 1/10/22 at 1:03 p.m.

Nurses' Notes, dated 1/3/22 at 10:11 p.m., by a LPN indicated the resident tested positive to COVID -19. Isolation precautions observed.

Nurses' Notes, dated 1/4/22 at 8:16 p.m., by a QMA, indicated the resident was COVID positive.

Nurses' Notes, dated 1/5/22 at 4:32 a.m., by a QMA, indicated the resident remained in isolation and was asymptomatic with no fever or shortness breath noted.

Nurses' Notes, dated 1/6/22 at 4:40 a.m., by a QMA, indicated the resident remained in isolation and has had diarrhea times 2. Imodium given. No fever or shortness of breath.

Nurses' Notes, dated 1/7/22 at 1:31 p.m., by a QMA, indicated temperature 98.0. No complaints or visible issues.

Nurses' Notes, dated 1/9/22 at 5:05 a.m., by a QMA, indicated the resident remained in isolation with no complaints of shortness of breath or fever.

Nurses' Notes, dated 1/9/22 at 10:24 a.m., by a QMA, indicated temperature 98.6. No issues or complaints.

Nurses' Notes, dated 1/10/22 at 4:26 a.m., by a QMA, indicated the resident remained in isolation with no complaints of shortness of breath or fever.

The vital signs section indicated a full set of vital signs including temperature and pulse oximetry was taken on 1/6/22.

There was no increased monitoring for the resident while they their positive for COVID-19.

10. The record for Resident D was reviewed on 1/10/22 at 2:15 p.m.

The vital signs section indicated a temperature and pulse oximeter were documented on 1/2 and 1/3/22 for the month of January.

There were no other vital signs including temperature and pulse oximeter recorded on a daily basis to monitor for signs and symptoms of COVID-19.

Information received from the Director of Wellness indicated the facility was currently in outbreak status with 11 positive residents and 4 positive staff.

Interview with the Director of Wellness on 1/10/22 at 1:12 p.m., indicated there was no documentation of daily COVID monitoring and increased monitoring for residents who currently have COVID. The facility only had a QMA working the midnight shift and they were not qualified to assess the resident's respiratory status. She was not able to find documentation of daily temperatures, vital signs, and pulse oximeter checks for the residents.

The Indiana Department of

	Health current and updated 1/4/22 "Long-term Care COVID-19 Clinical Guidance" policy indicated, "Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximeter. · Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximeter, and respiratory exam, to at least three times daily to identify and quickly manage serious infection." This State Residential Rule was cited on 12/1/21. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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