STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G440	A. BUILDING 00 B. WING	03/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

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W 0000 Bldg. 00	This visit was for a predetermined full recertification and state licensure survey. This visit included the Covid-19 focused infection control survey. Survey Dates: 3/1/21, 3/2/21 and 3/3/21. Facility Number: 000954 Provider Number: 15G440 AIM Number: 100244720 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/11/21.	W 0000		
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 7 of 12 incident/investigative reports reviewed affecting clients #3, #5, #7 and FC #1 (Former Client), the facility failed to conduct investigations of Client to Client (C2C) aggression. Findings include: On 3/1/21 at 1:37 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) The 8/31/20 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "[FC] returned to group home after being discharged from [Hospital Name] Hospital. [FC] was agitated upon arrival and kept	W 0154	**Timeliness and thoroughness of Investigations remains an ongoing issue. All trained investigators will be trained on the operations investigative process to ensure five-day completion and thoroughness of investigations.** **The facility will have evidence that all injuries of unknown origin are thoroughly investigated and reported to BDDS per reporting guidelines.** **All trained investigators will complete re-training on the facility policies and procedures**	04/02/2021

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

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	requesting to leave the home. Staff attempted to speak with [FC] to calm her down. [FC] refused redirection and began throwing art supplies and a plastic shelf in the home. [FC] was placed in an agency approved 1 person standing restraint for 10 seconds and released. [FC] walked to her room and calmed down. While staff was assisting another peer in the restroom, [FC] became agitated again and exited the home. Staff followed [FC] maintaining line of sight. [FC] stepped into the road in front of traffic. Staff used a 1 person walking restraint to remove [FC] from the road. Staff verbally redirected [FC] to enter the van and [FC] returned home with staff. Upon returning home, [FC] entered her room and began knocking over dressers. Staff placed [FC] in a 1 person standing restraint for 1 minute and released her. While staff was placing dresser back in place, [FC] ran into peer [client #7's] room and grabbed [client #7's] neck. Staff placed [FC] in a 1 person walking restraint for 3 minutes to separate [FC] from peer. [FC] lowered herself to the ground during restraint. [FC] stood up and attempted to be aggressive toward [client #7] again. Staff again placed [FC] in a 1 person standing restraint for 3 minutes and released her. [FC] sat on the ground during restraint then walked into the living room and sat on the couch. Staff spoke with [FC] until she calmed down and resumed normal activity. No injuries observed to [FC] or [client #7]. No damage to items in the home. Nurse notified. Plan to Resolve (Immediate and Long Term). Both individuals appear to be in good health. The use of this emergency restraint is approved in [FC's] plan. Staff will continue to follow BSP (Behavior Support Plan) in place from [Hospital Name] hospital until 30 day transitional meeting is scheduled for [FC]. Staff will continue to monitor and report any changes to their health. A C2C		**regarding their responsibilities to ensure that all incidents as defined by the policy are reported and investigated. The QIDP is responsible for initiating and completing initial investigation of injuries of unknown origin. The Quality Assurance Manager is responsible for ensuring that these incidents of injuries of unknown injury are thoroughly investigated, and follow-up is completed within the established timelines. The agency has implemented an electronic tracking systems and calendar reminders to ensure the administrator is able to implement corrective actions if the allegation is substantiated.**	

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	investigation will be initiated." There was no documentation the facility conducted an investigation of the incident. 2) The 9/5/20 BDDS incident report indicated, "Without prior incident, [FC] became agitated and began throwing peer [client #5's] personal items. [FC] threw [client #5's] television, PlayStation controller, and DVD player causing the items to break. [FC] was placed in an agency approved 1 person walking restraint for 3 minutes and walked out of [client #5's] bedroom. [FC] then sat down at the kitchen table in the home. [FC] picked up a glass and threw it at the wall causing the glass to break. [FC] was again placed in a 2-person standing restraint for 3 minutes and released. [FC] calmed down and resumed normal activity. No injuries observed. Nurse notified. Plan to Resolve (Immediate and Long Term). All broken items removed from the home. The use of this emergency restraint is HRC (Human Rights Committee) approved in [FC's] plan. Staff will continue to follow BSP in place from [Hospital Name] hospital until 30 day transitional meeting for [FC] is scheduled. Personal items for [client #5] will be replaced. Staff will continue to monitor and report any changes to their health. A C2C investigation will be initiated." There was no documentation the facility conducted an investigation of the incident. 3) The 9/10/20 BDDS incident report indicated, "[FC] became agitated while sitting in staff office with Residential Manager during her team meeting conference call. [FC] threw a drink at manager and ran out of the staff office threatening to leave the home. Staff verbally redirected and offered [FC] a			

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	snack. [FC] sat down in the living room and calmed down.[FC] then exited the living room and entered peer/roommate [client #5's] room and began throwing items. [FC] broke several make up items belonging to [client #5]. [FC] was placed in an agency approved 2 person standing hold for 3 minutes and released. [FC] knocked [client #5's] TV over causing it to break. [FC] was again placed in a 2 person standing hold for 3 minutes and released. [FC] continued aggressive behavior toward staff. 911 contacted. [County Name] Sheriff arrived and transported [FC] to [Hospital name] ER (emergency room) for evaluation. [FC] remains at [Hospital] on 09/11/20 awaiting psychiatric placement. Plan to Resolve (Immediate and Long Term). ResCare to remain in contact with [Hospital name] pending discharge or transfer. The use of this emergency restraint is HRC approved in [FC's] plan. Personal items for [client #5] will be replaced. A C2C investigation will be initiated." There was no documentation the facility conducted an investigation of the incident. 4) The 9/16/20 BDDS incident report indicated, "Without prior incident, [FC] walked toward peer/housemate [client #7] as she was getting cleaning supplies of out a closet in the home. [FC] stood in front of [client #7] not allowing her to walk away and drew her fist back threatening to hit [client #7]. Staff verbally redirected and separated individuals to prevent [FC] from hitting [client #7]. [FC] calmed down and resumed normal activity. No injuries observed. Plan to Resolve (Immediate and Long Term). Both individuals appear to be in good health. Staff will continue to follow BSP in place from [Hospital			

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	Name] Hospital until 30 day transitional meeting for [FC] is scheduled. Staff will continue to monitor and report any changes to their health. A C2C investigation will be initiated." There was no documentation the facility conducted an investigation of the incident. 5) The 9/18/20 BDDS incident report indicated, "[FC] became agitated about wanting to leave the group home for another location. [FC] threw dishes and a crockpot in the home onto the floor causing them to break. [FC] threw peer [client #5's] personal item off of her dresser. [FC] walked through the home throwing chairs causing a 3 inch hole in the kitchen wall. [FC] then entered peer [client #7's] room and knocked over [client #7's] dresser and television causing television (sic) to break. Television hit [client #7] on her leg when it was knocked over. [FC] refused attempted verbal redirection by staff. 911 contacted. [City] Police arrived and spoke with [FC]. Police declined transporting [FC] for evaluation. [FC] calmed down but resumed behavior approximately 40 minutes after police left the residence. [FC] threw a cutting board on the floor causing it to break. [FC] knocked over the TV (television) stand and TV in the living room causing them to break. [FC] entered peer [client #4's] room and broke the cable box and [client #4's] jewelry box. [FC] then set off the fire alarm and broke the cable box and the internet modem in the home. [FC] was placed in agency approved 2 person standing restraint for 3 minutes and released. Residential Manager notified. Manager arrived at the home and spoke with [FC] until she calmed down and resumed normal activity. No injuries observed on any of the individuals. Nurse notified. Plan to Resolve (Immediate and Long Term).			

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	Emotional support was offered to all individuals. All broken items removed from the home. Maintenance request submitted to repair broken items in the home and peer's personal items will be replaced. [FC] is currently staffed 1:1 (1 to 1) in the home. [FC] has been approved for waiver placement and is currently visiting homes to complete waiver transition. The use of this emergency restraint is HRC (Human Rights Committee) approved in [FC's] plan. Staff will continue to follow BSP (Behavior Support Plan) in place from [Hospital Name] Hospital until 30 day transitional meeting for [FC] is scheduled. A C2C investigation will be initiated." There was no documentation the facility conducted an investigation of the incident. 6) The 9/22/20 BDDS incident report indicated, "Without prior incident, [FC #1] got up from sitting in the dining room and walked out of the home. Staff followed [FC] maintaining line of sight. [FC] walked down the road in front of the home. Staff verbally redirected and spoke with [FC] until she calmed down and returned inside the home. [FC] continued behavior in the afternoon by entering peer [client #5's] room and throwing several of [client #4's] personal items. [Client #5's] Blu-ray player was broken when thrown. Staff placed [FC] in an agency approved 1 person walking restraint for 3 minutes to walk [FC] out of peer's room. [FC] was released and calmed down and resumed normal activity. No injuries observed. Plan to Resolve (Immediate and Long Term). Emotional support was provided to [client #5]. All broken items removed from the home. [Client #5's] personal items will be replaced. [FC] does not currently have any alone time allotted in her plan.			

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	The use of this emergency restraint is approved is [FC's] plan. [FC] has been removed from the home and temporarily placed at the day program facility located at [address] until a further placement option can be developed. All supports to remain in place at day program facility. [FC] has been approved for the CIH (Community Integration and Habilitation) waiver and is pending case management assignment and transition to a waiver services. A C2C Investigation will be initiated." There was no documentation the facility conducted an investigation of the incident. 7) The 9/25/20 BDDS incident report indicated, "[Client #3] was hanging towels outside to dry. Peer [client #5] tried to take to (sic) the towels down and [client #3] asked her to leave the towels alone. [Client #5] became agitated and pulled [client #3's] hair and smacked her on the head. [Client #3] then smacked [client #5] on her hands. Staff verbally redirected and separated Individuals. Both Individuals calmed down and resumed normal activity. No injuries observed. Nurse notified. Plan to Resolve (Immediate and Long Term). Both Individuals appear to be in good health. 24-hour head tracking Initiated for [client #3]. Staff will continue to follow [client #5's] BSP which addresses aggression. Staff will continue to monitor and report any changes to their health. A C2C investigation will be initiated." There was no documentation the facility conducted an investigation of the incident. On 3/2/21 at 3:15 PM, the AS (Area Supervisor) indicated the QIDP (Qualified Intellectual			

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	Disabilities Professional) usually does the investigations. The AS indicated the QA (Quality Assurance) department usually assigns the investigations to the QIDP to do. The AS indicated the QA department puts the comment indicating an investigation would be completed into the BDDS report and then put a calendar reminder (on the computer) of when it (the investigation) was due. The AS indicated C2C aggression should be investigated. The AS stated, "Investigations are to be completed within 5 business days." 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. Based on record review and interview for 1 of 3 clients in the sample (#1), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor client #1's program plans by failing to indicate whether or not client #1 met or did not meet her training objectives. Findings include: 1) On 3/2/21 at 12:23 PM, a review of client #1's record was conducted. Client #1 had quarterly reviews completed on 10/9/20 and 1/15/21. No documentation was provided of quarterly reviews completed in April 2020 or July 2020. -The 1/15/21 Quarterly Review of Program Plan Progress Months Reviewed: October, November, December signed by the QIDP indicated the following:	W 0159	**All QIDPs will receive retraining on coordination of client program plans and identification of progress toward meeting objectives. Program Manager will conduct a quarterly audit of all charts in the home to ensure client program plans are coordinated and client goals and objectives include identification of progress.**	04/02/2021

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	-"Goal: Self-Administration Objective: [Client #1] will throw her med cup in the trash after she has taken her medication with 3 verbal prompts 60% of the opportunities per month across three consecutive months. Progress: Month of (blank): 100 Month of (blank): 100 Month of (blank): 40 Status/Team Decision: (blank) -Goal: Money Management Objective: [Client #1] will identify coins and/or bills with 2 verbal prompts 50% of the opportunities per month across 3 consecutive months. Progress: Month of (blank): 100 Month of (blank): 100 Month of (blank): 100 Status/Team Decision: Repeat -Goal: Oral Care Objective: [Client #1] will brush her teeth for 2 minutes twice per day with hand over hand assistance from staff with 3 verbal prompts 65% of opportunities per month across three consecutive months. Progress: Month of (blank): 100 Month of (blank): 100 Month of (blank): 0 Status/Team Decision: (blank) -Goal: Hygiene Skills Objective: [Client #1] will wash her arms with hand over hand assistance with 2 verbal prompts 60% of the opportunities per month across three consecutive months. Progress: Month of (blank): 100 Month of (blank): 100 Month of (blank): 0 Status/Team Decision: (blank) -Goal: Dining Skills Objective: [Client #1] will help take her cup to the			

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	sink after dinner with staff assistance with 2 verbal prompts 60% of the opportunities per month across three consecutive months. Progress: Month of (blank): 100 Month of (blank): 71 Month of (blank): 93 Status/Team Decision: (blank) -Goal: Safety Skills Objective: [Client #1] will slow her pace when ambulating due to history of falls with 2 verbal prompts 50% of the opportunities across three consecutive months. Progress: Month of (blank): 100 Month of (blank): 22 Month of (blank): 100 Status/Team Decision: (blank) -Goal: Toileting Objective: [Client #1] will use the restroom every two hours with 2 verbal prompt 60% of the opportunities per month across three consecutive months. Progress: Month of (blank): 100 Month of (blank): 100 Month of (blank): 100 Status/Team Decision: (blank) The quarterly review did not indicate status or team decision of progress. On 3/2/21 at 1:56 PM, QIDP #2 (Qualified Intellectual Disabilities Professional) indicated the April and July 2020 quarterlies were during a period in which the previous QIDP was transitioning to another position and a new QIDP for the home had been hired. QIDP #1 stated, "I honestly do not think the quarterlies had been completed." QIDP #2 indicated she was unsure if the replacement QIDP completed them. QIDP #2 stated, "When this last QIDP left, I covered until [QIDP #1] was hired.			

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	9-3-3(a)			
W 0210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure a comprehensive functional assessment (CFA) was completed within 30 days of admission to the group home. Findings include: On 3/2/21 at 1:30 PM, a review of client #3's record was reviewed. Client #3 was admitted into the group home 5/3/19. There was no documentation the CFA was completed. On 3/2/21 at 3:15 PM, the AS (Area Supervisor) and QIDP #1 (Qualified Intellectual Disabilities Professional) were interviewed. The AS indicated the QIDP was responsible for ensuring the CFA was completed. The QIDP stated, "I do not know it if (the CFA) has been done.	W 0210	**Charts for all clients in the home have been reviewed and Programming Assessments have been updated where necessary.** **All Comprehensive Functional Assessments will be reviewed to ensure they are current and updated where necessary.** **All QIDPs will receive retraining to ensure Programming Assessments are completed upon admission and updated annually thereafter.** **Program Manager will conduct a quarterly audit of all charts in the home to ensure Programming Assessments are current and up to date.**	04/02/2021
	9-3-4(a)			
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 3 clients in the sample (#1 and #2), the facility failed to ensure the clients' comprehensive functional	W 0259	**All QIDPs will receive retraining on updating all client programming**	04/02/2021

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	assessments (CFA) were reviewed, at least annually, and updated as needed. Findings include: 1) On 3/2/21 at 12:23 PM, a review of client #1's record was conducted. Client #1's most recent CFA was dated 10/8/19. There was no documentation client #1's CFA was reviewed or updated since 10/8/19. 2) On 3/2/21 at 1:02 PM, a review of client #2's record was conducted. Client #2's most recent CFA was dated 10/8/19. There was no documentation client #2's CFA was reviewed or updated since 10/8/19. On 3/2/21 at 3:15 PM, the AS (Area Supervisor) and QIDP #1 (Qualified Intellectual Disabilities Professional) were interviewed. The AS indicated the CFA (Comprehensive Functional Assessment) was to be reviewed and updated annually. The AS indicated the CFA was to be updated during the annual. The AS indicated the QIDP was responsible for ensuring the CFA was updated. The QIDP stated, "I do not know it if (the CFA) has been done. 9-3-4(a)		**assessments according to their timelines.** **All Comprehensive Functional Assessments will be reviewed to ensure they are current and updated where necessary.** **Program Manager will conduct a quarterly audit of all charts in the home to ensure Programming Assessments are current and up to date.**	
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 1 of 8 clients present in the group home (#6), the facility failed to store client #6's medication securely at all times.	W 0382	**All staff in the home will be retrained on the agency medication administration policy with an emphasis on storage of medications.**	04/02/2021

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	Findings include: On 3/2/21 from 5:41 AM to 8:17 AM, an observation was conducted at the group home. At 6:24 AM, staff #2 left the medication room to get client #6. Client #6's Linzess (Irritable Bowel Syndrome) was in a medication cup on the desk. Staff #2 did not fully close the medication room door. Staff #2 was gone for 30 seconds. On 3/2/21 at 6:44 AM, staff #2 indicated medications should remain locked. Staff #2 stated, "I usually do not leave the medication room." On 3/2/21 at 3:15 PM, the AS (Area Supervisor) indicated the medications are to be locked behind two locks. 9-3-6(a)		**Administrative observations have been implemented in the home and will remain in place until the team determines it is appropriate to decrease the number of observations. This will ensure all corrections are implemented per ResCare policy and regulations. Ongoing weekly and monthly observations and review will continue with the QIDP and Area Supervisor over the location.**	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure staff conducted quarterly evacuation drills for each shift of personnel. Findings include: On 3/1/21 at 1:18 PM, a review of the facility's evacuation drills was conducted and indicated the following issues: -During the evening shift (2:00 PM to 10:00 PM), the facility failed to conduct evacuation drills from 5/10/20 to 11/23/20.	W 0440	**The facility has a monthly drill schedule that is provided to the Residential Manager that outlines when drills are to take place, including each shift, so that at least one drill is conducted on each shift at least every three months. Unless there is inclement weather during the drill, all residents are evacuated from the home during each drill conducted at the home on all shifts. The Residential Manager will**	04/02/2021

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	15G440	A. BUILDING 00 B. WING	03/03/2021

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	-During the night shift (10:00 PM to 6:00 AM), the facility failed to conduct evacuation drills 3/1/20 to 6/18/20. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 3/2/21 at 3:15 PM, the AS (Area Supervisor) indicated the evacuation drills were to be completed once per shift per quarter. 9-3-7(a)		**receive training on their responsibilities for ensuring that drills are completed by the direct care staff as outlined in the schedule. The Area Supervisor will be responsible for conducting this training.** **The Residential Manager also reviews and signs the Drill Reports indicating that any issues identified during the drill are followed-up appropriately.** **The Residential Manager is responsible for assuring drills are properly submitted to the office and filed at the home.** **The Area Supervisor will monitor that quarterly drills are completed as scheduled. Any drills not conducted as scheduled will be followed up with the Residential Manager.** **The Area Supervisor will submit completed drills to the Quality Assurance Manager for review by the Safety Committee on a quarterly basis.** **Administrative observations have been implemented in the home and will remain in place until the team determines it is appropriate to decrease the number of observations. This will ensure all corrections are implemented per ResCare policy and regulations.** **Ongoing weekly and monthly observations and review will continue with the QIDP and**	

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			Area Supervisor over the location.	
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 8 of 8 clients in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure 1) staff sanitized her hands prior to administering medications to clients #4, #6 and #8 and 2) staff implemented proactive/preventative infectious Covid-19 control measures. Findings include: On 3/1/21 from 4:01 PM to 6:18 PM, an observation was conducted at the group home. At 4:01 PM, the RM (Resident Manager) greeted the surveyor at the front door. The RM requested to take the surveyor's temperature. The RM did not ask the surveyor screening questions. At 4:16 PM, staff #2 sat at the dining room table between clients #1 and #7. Staff #2 had a facemask on with her nose uncovered. At 4:24 PM, the RM was applying hydrocortisone (anti-itch) cream to client #7's face with a gloved hand. The RM was wearing a facemask with her nose uncovered. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 3/2/21 from 5:41 AM to 8:17 AM, an observation was conducted at the group home. At 5:41 AM, staff #2 greeted the surveyor at the front door. Staff #2 requested to take the surveyor's temperature. Staff #2 did not ask the surveyor screening questions. At 6:06 AM, staff #2 assisted client #4 to the dining room table by	W 0455	**All staff in the home will be retrained on Infection Control Practices with an emphasis on proper donning of facial coverings (covering the face from above the nose to below the chin), sanitizing their hands and encouraging clients to sanitize their hands before and after medication administration, meal preparation and clean up, meal consumption, and between giving care to clients, sanitizing all areas where clients may come into contact with potential infectious materials, and conducting of Infection Control Screenings for all visitors prior to allowing entry into the home. Administrative observations have been implemented in the home and will remain in place until the team determines it is appropriate to decrease the number of observations. This will ensure all corrections are implemented per ResCare policy and regulations. Ongoing weekly and monthly observations and review will**	04/02/2021

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	holding client #4's gait belt. Staff #2 had a facemask on with her nose uncovered. At 6:07 AM, staff #2 assisted client #7 to the dining room table using her gait belt. Staff #2 had a facemask on with her nose uncovered. At 6:11 AM, staff #2 poured milk for clients #4 and #8 and water for client #7 and brought them to the dining room table. Staff #2 had a facemask on with her nose uncovered. At 6:13 AM, staff #2 began preparation for medication pass. Staff #2 did not sanitize the desk or her hands prior to setting the MAR (Medication Administration Record) binder and medication cups on the desk. At 6:15 AM, staff #2 administered medications to client #8. Staff #2 did not sanitize her hands prior to administering client #8 her medications. Staff did not request client #8 to sanitize her hands. At 6:19 AM, staff #2 prepared medications for client #6. Staff #2 did not sanitize her hands. At 6:20 AM, staff #2 knocked over the medication cup which contained Linzess (Irritable Bowel Syndrome) for client #6. Staff #2 picked the medication up from the desk with her un-sanitized hand and placed into the medication cup. At 6:26 AM, staff #2 administered medication to client #6 with a facemask on and her nose uncovered. Staff #2 did not sanitize her hands and did not request client #6 to sanitize her hands. At 6:29 AM, staff #2 prepared medications for client #4. Staff #2 did not sanitize her hands until after administering the medication to client #4. Staff #2 did not request client #4 to sanitize her hands. At 7:01 AM, the RM (Resident Manager) and staff #2 assisted client #5 with frying bacon. The RM and staff #2 had face masks on with their noses uncovered. At 7:36 AM, staff #2 stood next to client #8 at the dining room talking. Staff #2 had a facemask on with her nose uncovered. At 7:44 AM, client #8 sneezed four times while sitting at the dining room table. Client #8 did not cover her nose when she		**continue with the QIDP and Area Supervisor over the location.**	

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	sneezed. Client #8 was not prompted to cover her nose when she sneezed. Client #8 then took a napkin from the dining room table, blew her nose and laid the napkin back on the dining room table. Staff #2 offered client #8 hand sanitizer but did not prompt client #8 to dispose of the napkin in the trash. On 3/2/21 At 6:44 AM, staff #2 stated, "Yes, I should have sanitized the desk prior to passing medications." Staff #2 stated, "Yes, I should have sanitized my hands between each client." Staff #2 indicated she should have also had each client sanitize their hands. Staff #2 stated, "No, I should not have administered the medication after it was dropped. I should have called the RM (Resident Manager) or nurse." On 3/2/21 at 7:04 AM, the PM (Program Manager) indicated face masks are to be worn over the nose and under the chin. On 3/2/21 at 3:15 PM, the AS (Area Supervisor) and DON (Director of Nursing) were interviewed. The AS indicated screening questions were to be asked of all individuals entering the home. The DON stated, "The visitor should be filling out the sheet or asking the visitor the questions and completing for them." The DON indicated there was a place for visitor signature on the screening sheet. The AS indicated staff training for COVID-19 infection control included the importance of hand washing, how to wear PPE (Personal Protection Equipment), signs and symptoms of COVID-19 and when to report. The CDC (Center for Disease Control) website https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html#source-control was reviewed on 3/2/21 at 3:00 PM. The CDC website indicated			

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	the following: -"Have a plan for visitor and personnel restrictions -Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms consistent with COVID-19 before starting each shift/when they enter the building. Send visitors and personnel home if they have a fever (temperature of 100.0 oF (degrees) or greater) or symptoms consistent with COVID-19." -Educate residents, family members, and personnel about COVID-19: ·Describe actions residents and personnel can take to protect themselves in the facility, emphasizing the importance of social (physical) distancing, hand hygiene, respiratory hygiene and cough etiquette, and source control. Encourage source control ·Everyone in the facility should practice source control. ·Personnel should wear a facemask (or cloth face covering if face masks are not available or only source control is required) at all times while they are in the facility. ·Visitors should wear a cloth face covering while in the facility. Source Control: Use of a cloth face covering or facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing." 9-3-7(a)			