STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00362950, IN00362670, IN00361847, IN00360406 and IN00355663. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00362950 - Substantiated. No deficiencies related to the allegations are cited . Complaint IN00362670 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00361847 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00360406 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00355663 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: September 21, 22 and 23, 2021 Facility number: 000098 Provider number: 155187 AIM number:100290890 Census bed type: SNF/NF: 110 Total: 110 Census payor type: Medicare: 13 Medicaid: 93 Other: 4 Total: 110	F 0000		

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/29/21.			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of			

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	communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on record review and interview, the facility failed to properly prevent and/ or contain COVID-19 related to not monitoring residents	F 0880	Resident B was assessed and no adverse effects were noted. Resident J had an order placed	10/08/2021

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	for signs and symptoms of COVID-19 per guidelines for 2 of 5 resident records reviewed. (Residents B and J) Finding includes: 1. Resident B's record was reviewed on 9/22/21 at 10:40 a.m. The resident resided in a Green zone room (an area where residents are not positive or in observation isolation for COVID-19). The resident's September 2021 Medication Administration Record indicated the resident was not monitored for temperature, oxygen saturation or symptoms of COVID-19 on September 1, 2, 3, 7, 8, 10, 15, 18 and 21. A Physician's Order, dated 6/21/21, indicated to monitor for fever, feeling feverish, cough, shortness of breath, fatigue, sore throat, runny or stuffy nose, muscle pain, body aches, nausea, diarrhea, loss of taste/ sense of smell. Record temperature and oxygen saturation daily. 2. Resident J's record was reviewed on 9/22/21. The resident had tested positive for COVID-19 on 8/31/21 and was placed on contact and droplet isolation. The resident was monitored for temperature, oxygen saturation and symptoms of COVID-19 three times daily from 9/1/21-9/8/21. There was no COVID-19 monitoring after 9/8/21. A Physician's order, dated 8/31/21/21, indicated to monitor for fever, feeling feverish, cough, shortness of breath, fatigue, sore throat, runny or stuffy nose, muscle pain, body aches, nausea, diarrhea, loss of taste/ sense of smell. Record temperature and oxygen saturation every shift (three times daily) until 9/8/21. There was not an additional order to resume daily monitoring		for monitoring COVID-19 signs and symptoms prior to the date of compliance. Resident J was assessed and no adverse effects were noted. All residents have the potential to be affected. An audit of all residents was completed 9/24/21 to ensure all residents have COVID-19 monitoring orders in place. Any residents identified had orders put in place 9/24/21. The Corporate Infection Preventionist educated al l licensed nursing staff related to the facility policies for Infection Surveillance and Infection Prevention and Control as well as education regarding the current IDOH/CDC guidelines for Assessment of Residents prior to the date of compliance. The RDCO/IP/DNS will audit 5 random residents, to include all units, orders for COVID-19 monitoring/screening five times/week x 2 months, then three times per week x 2 months, then weekly x 2 months to ensure screening/monitoring is being completed per facility/IDOH/CDC policy/guidelines. The RDCO/IP/DNS will audit 5 random residents, to include all units, Medication Administration	

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	after 9/8/21. The Indiana Department of Health document, "Long-term Care COVID-19 Clinical Guidance", updated 9/7/21, indicated, "...Screen all residents daily for COVID-19 symptoms. Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, at least 3 times daily to identify and quickly manage serious infection...." Interview with the Director of Nursing (DON), on 9/22/21 at 11:40 a.m., indicated all residents were monitored for symptoms of COVID-19 daily. Residents on transmission based precautions were monitored three times daily while in isolation. During a follow up interview at 2:54 p.m., the DON indicated there were "holes" in Resident B's record, and that they had not initiated daily monitoring for Resident J after the isolation was completed. 3.1-18(a)		Records for COVID-19 monitoring/screening five times/week x 2 months, then three times per week x 2 months, then weekly x 2 months to ensure screening/monitoring is being completed and documented per facility/IDOH/CDC policy/guidelines. The RDCO/IP/DNS will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate infection control practices and complying with the solutions identified above. This will occur for no less than 6 weeks, until compliance is maintained. Results of audits will be reviewed in QAPI monthly x 6 months and the DPOC will be reviewed, updated and changed as needed for sustaining substantial compliance with the DPOC.	
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement			

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	and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms			

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	consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Based on record review and interview, the facility failed to properly monitor the transmission of COVID-19 related not testing staff for COVID-19 per guidelines for 2 of 3 staff records reviewed. (Employees 1 and 2) Finding includes: The employee COVID-19 testing records for the past four weeks were reviewed on 9/23/21 at 9:00 a.m. Employee 1, an unvaccinated CNA, was hired on 8/31/21. She was tested for COVID-19 on 9/2 and 9/10/21. The record lacked testing results for 9/6, 9/13 and 9/16/21. Employee 2, an unvaccinated housekeeper, was tested on 8/26, 9/2, 9/9 and 9/16/21. The record lacked testing results for 8/30, 9/6 and 9/13/21. The Indiana Department of Health document,	F 0886	No residents were identified. All residents have the potential to be affected. Employee 1 (CNA) and Employee 2 (housekeeper) were immediately educated on the need to be tested for COVID-19 per facility policy and IDOH/CDC guidelines. The IP/DCE/designee educated all staff regarding the facility policies Facility Covid-19 Testing Infection Control Policy and COVID-19 Testing for Healthcare Personnel to include any staff who is required to be tested and is not tested will be removed from the schedule until testing is completed. Staff were also educated on the IDOH/CDC guidelines for	10/08/2021

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	"Long-term Care COVID-19 Clinical Guidance", updated 9/7//21, testing table indicated when community COVID-19 activity was high, greater than 10% positivity rate, unvaccinated staff should be tested a minimum of two times weekly. Interview with the Director of Nursing on 9/22/21 at 11:40 a.m., indicated the county positivity rate had been over 10% for the past month and unvaccinated staff were being tested twice weekly on Monday and Thursday. On 9/23/21 at 10:40 a.m., the Assistant Director of Nursing indicated there were no additional test results for the above employees.		outbreak testing and testing guidelines for nursing homes. All education was completed prior to the date of compliance. The DNS/Designee will audit all staff COVID-19 testing results to ensure testing is completed per the guidelines/policy of at least one time per week. Testing frequency/audits will be adjusted as needed related to the county positivity rate/outbreaks. Audits will occur for 6 months to ensure testing occurs per the guidelines/policy. Audits will be submitted to QAPI monthly for 6 months to ensure increased compliance and will adjust audits accordingly.	