DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155222 | A. BUILDING 00<br>B. WING | 10/07/2021 |

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| KOKOMO HEALTHCARE CENTER | 429 W LINCOLN RD<br>KOKOMO, IN 46902 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00363003 and IN00363321. This visit included a COVID-19 Focused Infection Control Survey. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy.<br><br>Complaint IN00363003 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600.<br><br>Complaint IN00363321 - Substantiated. No deficiencies related to the allegations were cited.<br><br>Survey dates: October 4, 5, 6 and 7, 2021.<br><br>Facility number: 000127<br>Provider number: 155222<br>AIM number: 100291430<br><br>Census Bed Type:<br>SNF/NF: 68<br>Total: 68<br><br>Census Payor Type:<br>Medicare: 6<br>Medicaid: 51<br>Other: 11<br>Total: 68<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 10/14/21. | F 0000 | | |
| F 0600<br>SS=J | 483.12(a)(1)<br>Free from Abuse and Neglect | | | |

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| Bldg. 00 | §483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>Based on interview and record review, the facility failed to ensure a resident was free from physical abuse when a resident with known aggressive behaviors (Resident B) had a verbal and physical altercation with another resident (Resident C) for 2 of 3 residents reviewed for abuse. Resident C had to be evaluated in the Emergency Room (ER) after the physical altercation.<br><br>The Immediate Jeopardy began on September 18, 2021 when Resident B verbally and physically attacked Resident C. Resident C was assessed and noted with right eye swelling, petechiae (a small red or purple spot caused by bleeding into the skin) by the hairline and an abrasion to the right elbow and the left ankle. The resident complained of pain and double vision. Resident C indicated she feared for her life. Resident B was known to have verbal and physical aggressive behaviors. The Executive Director (ED), Interim Director of Nurses (DON) and Regional Director of Clinical Operations (RDOC) were notified of the immediate jeopardy at 2:21 p.m., | F 0600 | 1) 1. 9/18- JD comes to south unit asking for police to be called over his remote control. KJ comes out of room and ask JD to please stop yelling.<br>JD reacts by engaging in a physical altercation with KJ<br>Two staff began separating JD from KJ, while other CNA paged overhead for assistance to the South unit. Both residents immediately separated and JD began walking to his room with two staff members.<br>1:1 initiated for JD to ensure safety<br>Nurse called 911<br>KJ was assessed and sent to ER for evaluation and treatment<br>JD entered room and staff found an extra remote to assist with deescalating JD<br>Nurse attempted to complete a full assessment of JD and resident | 10/11/2021 |

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| | on 10/06/21. The immediate jeopardy was removed on 10/07/21, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include<br><br>1. The record for Resident B was reviewed on 10/4/21 at 3:31 p.m. Diagnosis included, but were not limited to, mild intellectual disorder and impulse disorder.<br><br>A review of Resident B's progress notes indicated:<br><br>On 9/6/21 at 1:21 p.m., the resident refused assessment related to his G-tube being flushed. He would not let his stomach be seen. The resident was scheduled for dialysis and refused for his family member to transport him stating "I'm in pain and my b**** are on fire, I want to go to the hospital." The MD (Medical Director) was notified and indicated to transfer the resident to the ED (Emergency Department) for evaluation. The resident started yelling "your crazy, get out of my room the ride is 1,067 dollars and I'm not going to the hospital." His family member was present and the resident would not agree to go to the hospital or dialysis.<br><br>On 9/6/21 at 3:29 p.m., the resident refused all care and would not let the nurse do an assessment or check his G-tube. The resident yelled out and stated "get the f*** out of my room you're not looking at me."<br><br>On 9/6/21 at 5:50 p.m., staff answered the resident's call light and the resident immediately | | continuously refused assessment.<br>MD, ED, Family, and DON notified of incident<br>Police arrive to facility and escort Davis to hospital<br>2) 2 All other residents that were on the south unit had the potential to be affected. Resident interviews initiated and completed with no findings of other residents being fearful or affected by the occurrence at this time. Skin assessments completed on all residents with BIMS of 11 or lower with no findings noted.<br>3) 3. ED/DON/Designee completed education with all staff on the following policies: Resident Rights, Indiana Abuse, Neglect, and Misappropriation, and De-escalation process.<br>4) 4 The ED/DON/SSD/Designee will interview 5 resident weekly x 1 month, then 10 residents x 2 months to ensure all residents residing in the facility are free from abuse.<br><br>**Quality Assurance and Performance Improvement (QAPI):**<br>The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. | |

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began yelling "get the h*** out of my room. I don't want you in here. Get out." Staff left the room and the resident turned his call light back on. He had been very loud and disruptive to others on this hall.

On 9/7/21 at 6:53 a.m., the resident was yelling and verbally aggressive toward the staff. He was asked to go to his room in a nice, calm manner. He said in a loud voice "I do not have to listen to you. I am my own boss." Staff asked him to go to his room, he paced to the north door side entrance by therapy and back. The CNA asked the resident to go to his room and the resident replied "he didn't have to listen to a n*****." When he went to his room, he came out of the room and told two female residents to stop looking at him, slammed his door and went into his room.

On 9/7/21 at 2:21 p.m., the resident's family was called and was at the facility but were not effective in de-escalating the resident's behavior or agitation. He stayed in his room and calmed himself. Staff used interventions in place such as ensuring his safety and ceasing interaction.

On 9/7/21 at 2:25 p.m., Social Services followed up in regards to the behaviors on 9/6/21 at 3:29 p.m. and 5:50 p.m., when the resident was yelling and cursing at staff and refusing care. The staff attempted to explain care and the resident continued to yell at staff to get out of his room. Staff ceased interaction and the resident calmed.

On 9/7/21 3:29 p.m., Resident B was shouting in the hallway, pacing rapidly and yelling at everyone "get out of my way." He was verbally abusive to staff, refused any interventions, finally went into his room and slammed the door.

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Earlier in the day, the resident was in the administration office and refused to leave. He stood and stared at people going past his room. He was non-compliant with instruction.

On 9/9/21, the resident was seen by the Nurse Practitioner for aggression: verbal per staff reports and indicated to start Depakote DR (delayed release) 125 mg (milligram) twice a day for mood stabilization. Staff reported the patient was irritable and at times verbally aggressive with staff and residents.

On 9/13/21 at 6:01 p.m., the resident was sent to the hospital per the DON (Director of Nursing) and MD for lower abdominal pain. The resident did not get his dialysis completed because he refused to wear a mask. He refused vital signs to be taken and refused Tylenol for pain.

On 9/15/21 at 7:32 a.m., the resident refused to have his blood pressure taken three times. Resident became very irritated.

On 9/16/21 at 10:23 p.m., the resident asked the staff for a hug. Staff gave the resident a hug and he proceeded to grab the staff's bottom, kiss her on the cheek and attempted a second time. Staff pulled away and indicated it was inappropriate. The resident continued to ask her to come to his room. Staff notified the ED (Executive Director) and the resident was escorted off the hall.

On 9/17/21 at 1:29 p.m., the resident's family came to the facility to take the resident to dialysis, after several attempts, the resident continued to refuse to comply. The resident refused to have dialysis done today. POA (Power of Attorney) aware. ADON (Assistant Director of Nursing), ED and MD aware.

On 9/18/21 at 8:26 a.m., Resident B was involved in a verbal altercation with a female peer. As staff were intervening, the resident made physical contact with the female peer and with staff. The resident was immediately placed on 1:1 and redirected away from the situation. MD notified. KOPD (Kokomo Police Department) was notified and responded to the facility. KOPD took the resident to the hospital for evaluation/emergency detention. His family was notified. Then ED and DON were notified. The resident refused assessment at the time of the incident but verbal assessment revealed no injuries or signs/symptoms of pain.

2. The record for Resident C was reviewed on 10/4/21 at 2:51 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension and acquired absence of other left toe(s).

A Quarterly MDS (Minimum Data Set) assessment, dated 9/20/21, indicated Resident C's BIMS (Brief Interview for Mental Status) was scored at 15 which indicated the resident was cognitively intact. Section G for Functional Status indicated for transfers (how the resident moved between surfaces) the resident was an extensive assist of one person. She used a wheelchair.

A review of Resident C's progress notes indicated:

On 9/18/21 at 8:12 a.m., Resident C was involved in a verbal altercation with a male peer. The male peer made physical contact with the resident resulting in Resident C landing on the floor. Resident C was assessed and noted with

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| | right eye swelling, petechiae by the hairline and an abrasion to the right elbow and the left ankle. The resident complained of pain and double vision. The MD was notified and an order to send the resident to the ER for evaluation was ordered.<br><br>On 9/18/21 at 1:05 p.m., Resident C returned from the ER with an ace bandage on her right wrist. An order to follow up with ortho was put in the EMR (Electronic Medical Record) to schedule on Monday due to the office was closed today.<br><br>On 9/18/21 at 4:06 p.m., a new area abrasion was noted to the left outer ankle.<br><br>On 9/20/21 at 11:06 a.m., the X-ray from the ER visit showed no acute fracture.<br><br>A letter from the Deputy Prosecuting Attorney, dated 9/29/2021, indicated the office filed charges against Resident B. It was their desire to ensure the full impact of the offense on Resident B was brought to the attention of the Court. The letter was the first communication to emphasize they would vigorously protect Resident C's rights as a victim at all stages of the proceeding of the case.<br><br>A review of the facility's written staff statements indicated:<br><br>QMA 3 indicated, on 9/18/21 at approximately 6:30 a.m., she was walking down the hall to the south unit when she heard a page for a nurse to south. When she entered onto the unit the other staff told her Resident B threw Resident C out of her wheelchair, punched her in the head and was kicking her. Resident C was on the ground and | | | |

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Resident B was in the dining room. As Resident B proceeded to walk off the unit, he picked up the narcotic book and threw it at QMA 3. He then kicked CNA 1 in the back and threw the wet floor sign at her. At approximately, 7:00 a.m., he came down to the south unit again. He stood at the nurses station and asked QMA 3 "do you want some." QMA 3 politely said please go back to your hall. He said f*** you and charged at QMA 3. He ran and picked up a spray bottle and was going to throw it so QMA 3 took off running. Then he went and ran towards CNA 4.

CNA 1 indicated, on 9/18/21 at approximately 6:30 a.m., she was walking past the south hall and heard Resident B yelling and screaming at another resident (Resident C). At that point, she found out Resident B threw Resident C out of her wheelchair and was beating her up. He started to come back at Resident C once she was back in her wheelchair and was heading down the hall. CNA 1 stepped in between them because Resident B was trying to kick and attack Resident C again. She stood in the middle of the residents to help avoid further incident. Resident B then kicked CNA 1 in her back and threw a wet floor sign at her. He then proceeded to go down the hall back to his room while continuing to yell and threaten Resident C's life with knives. CNA 1 then told Resident C to go to her room for safety.

CNA 2 indicated, on 9/18/21 at 6:30 a.m., she did 1:1 observation with Resident B at this point. He was in his room yelling and pacing. Then he came out of his room and was headed toward the south hall to the nursing station. He starting yelling, screaming and ran toward the CNAs behind the desk. He picked up a bottle and tried to throw it but they had all moved away. He then

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headed back to the north hall and was yelling in his room until he was escorted out of the building by the police.

During an interview, on 10/5/21 at 1:40 p.m., the ED indicated the staff on the unit was QMA 3 who witnessed the altercation. The Regional Nurse Consultant completed the documentation in the progress notes based on QMA 3's statement. The Regional Nurse Consultant was not in the building when the event happened. The altercation occurred on the south unit at the nurses station.

During an interview, on 10/5/21 at 2:29 p.m., Resident C indicated Resident B came down to the south hall a lot. He did not belong on the south hall. He lived on the central hall. He came to the south hall and was yelling. He had been coming to the south hall and was yelling the whole week. The rest of the residents were asking "who was yelling?" and they did not like it. Residents need their rest. Resident C went out to the hallway and he was at the end of the medical cart at the nurses station. Resident C asked Resident B if he could please tone the yelling down. He cussed Resident C out, called her a f****ing b**** and hit her in her ear. He grabbed her head band and yanked her out of her wheelchair. When she went on the floor, she hurt her right hand and wrist. He hit her in the head and kicked her in the right side and back. Then he tried to choke her. She had to put her thumb in his neck because he was on the floor grabbing hold of her. He hit her in her head while she was on the floor. He came back at her 3 or 4 times. CNA 1 drug him off of her. Resident C indicated "she was afraid for her life." She thought he was going to kill her. He came back later and Resident C was back in her room, he said "where

is that f****ing b**** I am going to kill her." He had come down before on the south unit, after midnight and would yell a lot of times. It was worse on September 18th. Some of the staff would not do anything about his yelling. She did not know if he was yelling at staff or a resident but he was disturbing the peace. She had not had any trouble with him before.

During an interview, on 10/5/2021 2:56 p.m., the Social Service Director (SSD) indicated she spoke with Resident C and she was pretty upset. Resident C indicated to her Resident B grabbed her, threw her out of her wheelchair, hit and kicked her and threatened to kill her. Resident C was terrified and begged her not to let him come back. She indicated the situation was awful, the staff had to pull Resident B off of Resident C. Resident B's behaviors were agitation, quick to yell at staff and irritability. He was one if you approached him, you needed to give him options, if he felt like staff made a decision for him it would agitate him. His family would increase his behaviors. She would hear him get agitated. She did not hear him in the hallways yelling but would see him in his room clenching his fists. Most of his behaviors were in the evenings, he would go to the other units, get close to the staff and be very demanding and yell.

During an interview, on 10/5/21 at 3:25 p.m., CNA 4 indicated she was on the south hall with CNA 5. The QMA was late and was not there yet. Resident B kept coming to the south unit and was upset over a remote control. He wanted it fixed. He was mad about it. CNA 4 and 5 tried to redirect him but it was not working. He came back and Resident C asked Resident B if he would quiet it down because she was trying to sleep. Resident C said he was disturbing

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| | everyone. Resident C was not loud, she was talking in a normal tone and asked Resident B to be quiet. He pulled her out of the wheelchair, hit her in the side of the head, grabbed her head and pulled her out of the wheelchair. He called her a f****ing b****. CNA 4 was behind the nurses desk and this occurred right outside the nurses station on the south hall. Only CNA 4 and 5 were there. Right after it happened, QMA 3 rounded the corner and the other girls were coming. He kicked one of the staff in the back and threw a floor sign at her. They had to get him to his room. CNA 4 indicated she was in shock and did not know what to do. She grabbed Resident C and pulled her away. Resident B and Resident C were on the floor, close to the tv room, in the doorway. She pushed Resident B off of Resident C and grabbed Resident C because he would not let go of her. He did not hit CNA 4. CNA 5 called for help in the intercom and then another staff member came around the corner to assist. Everyone else started coming down to the south hall. CNA 4 indicated she was scheduled for the day shift. The midnight shift QMA left before she arrived for the day shift. She quit. Resident B would come to the unit a lot in the mornings or during the night shift. He would roam the building when he was agitated. CNA 4 indicated she had worked on all three different shifts before and he was down on the south hall many times and sometimes he would be yelling. Most of the residents were annoyed by his yelling. They would be upset because he would wake them up in the middle of the night yelling. CNA 4 indicated she was afraid of him because she had seen him attack her coworkers. He chased her around the unit after the incident with Resident C. He did not try to go in the residents' rooms. He was just chasing CNA 4 and QMA 3. He was saying to QMA 3 "b**** you want a piece of me" | | | |

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and called her a n*****. He chased CNA 4 and QMA 3 and CNA 4 indicated they went into the locked linen room to get away from him. After the incident, Resident C complained her eyes hurt, she had a headache and blurred vision. She had a red arm, he had dragged her arm and her arm was red from hitting the floor.

During an interview, on 10/5/21 at 3:36 p.m., QMA 3 indicated she arrived on the unit when the altercation with Resident B and C had ended. When she went around the corner, CNA 4 and 5 were breaking the altercation up. Resident C was on the ground and Resident B was in the doorway. Resident B stomped off and threw the narcotic book at QMA 3. He kicked CNA 1 in the back.

During an interview, on 10/5/21 at 3:56 p.m., CNA 5 indicated she was working the day shift, it was before 6:30.
CNA 5 and CNA 4 were at the nurses station getting started for the day. Resident B kept coming to the south hall talking about a remote. He was talking loudly. He was asked to go back to his room and talk to his nurse. He wanted the police called over a remote. He was angry. He just kept walking back and forth. He would leave then come back and holler more. CNA 4 indicated she asked him to talk to his nurse. He got more angry. Resident C came out and asked him to calm down since he had been screaming for the 4th day in a row. Other residents were hollering from their room for him to be quiet.
He grabbed Resident C out of her wheelchair and started hitting and kicking her. She called on the intercom for help. Resident B had a good grip on Resident C. She paged all nursing staff to the south hall. Resident B kept coming back to attack her. He kicked her in the head. Then QMA 3

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| | came around the corner. Resident B said something to QMA 3, she asked him to go back to his hall. He grabbed the narcotic book off the med cart and threw it at QMA 3. She heard shouting and heard a commotion. Staff took Resident C back to her room. Resident B went back to his room and you could still hear him hollering. Staff had tried to call the ED and she did not answer. Staff was able to contact the unit manager and the unit manager indicated she was coming into the facility and to put him on 1:1. Resident B came back to the south hall, looked at QMA 3 and said "you want a piece of me" went behind the nurses station and charged at QMA 3. CNA 5 indicated she called the police from the linen closet she was in with CNA 4 because Resident B was out of control. It was not long before the unit manager arrived at the facility. Then the police arrived. A lot of residents were afraid of him. She worked PRN (as needed) and did not work a lot so this was her first encounter with him. Residents had told her before Resident B hollered a lot. CNA 5 indicated she was afraid of Resident B because she did not have training on how to deal with that type of aggression. Resident B was running full force and kicking. She heard other staff say they were afraid of him because the smallest things would set him off. She felt like it could have been prevented because the facility was not the proper place for him. She did not know if they were trying to place him somewhere else.<br><br>During an interview, on 10/6/21 at 11:41 a.m., CNA 1 indicated on 9/18/21, she was coming inside the building after taking the trash out and she saw Resident B walking away and then he was coming back for Resident C again. She did not witness any of the altercation as it had already ended. She saw Resident B going after Resident | | | |

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C so she stepped in the middle to make sure he did not get to Resident C. CNA 1 indicated Resident B kicked her in the back and threw a wet floor signs at her. He then proceeded to walk away, she followed him and closed all the resident doors to make sure he did not go anywhere. She observed Resident C's face was red, her arm was red, you could tell someone had touched her. Resident B was amped up by the time she came into work that morning. He was screaming and threatening people. This was an every day thing for him. The CNAs did not like to be in his room by themselves. Resident B was strong. The behaviors were an every day thing for Resident B. A lot of the residents seemed afraid of him. When Resident B was in the hallway, it was scary to walk by him. Everybody was on edge when he was out and about in the hallways and raging in his violence. Resident B would walk all units and yell. He would scream in residents faces and threaten them. He also would go to the nurses station and threaten staff and talk about killing the residents and the staff.

During an interview, on 10/6/21 on 12:11 p.m., CNA 2 indicated on 9/18/21, she was working from 6 a.m. to 2 p.m. When she came in, Resident B was by the entrance doors in the front lobby. Then the next time she saw him was after the altercation, he was back in his room so she was doing the 1:1 with him. While on 1:1, he left his room and walked to the south hall again and chased one of the staff behind the nurses' station. She indicated she was following him when he was chasing the staff on the south hall and tried to talk him into going back to his room but there was no reasoning with him. Resident B went behind the nurses' station and started yelling and screaming at the QMA/nurse and then he tried to throw a bottle at her. When he went to throw it,

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he stumbled and the QMA/nurse was gone. She took off down the hall so he could not throw it at her. He then went back to his room, CNA 2 followed him and then the police showed up.

During an interview, on 10/6/21 at 2:09 p.m., Resident G who also resided on the same unit as Resident B, indicated Resident B followed her all the time and yelled at her. She indicated he would ask her why the other residents did not like him and she told him it was because of how he acted. He hurt the staff before. She indicated she told the staff she was afraid the next person to get hurt would be a patient. She carried her scissors with her because she did not feel safe as he always went after women. She tried to avoid him. He would go to other halls and yell, it made her cringe when he would start yelling. He did this every day.

A current policy, titled " INDIANA Abuse & Neglect & Misappropriation of Property" revised on 5/14/2020 and received from the DON on 10/4/21 at 2:50 p.m., indicated, "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents...In the event the alleged abuse involves a resident-to-resident altercation, the residents will be placed in separate areas by the staff and the appropriate physical assessments will be completed on each resident...Aggressive residents may be placed in a quiet are to reduce stimulation...."

The Immediate Jeopardy that began on 9/18/21 was removed on 10/7/21 when the facility completed the following: The ED and DON

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| | completed education for all staff on "Indiana Abuse & Neglect & Misappropriation" policy, "Resident Rights" policy and behavior de-escalation process, management and notification. The facility completed interviews for all residents who could be interviewed and head to toe assessments for residents to determine if they felt safe at the facility and determine if any other abuse had occurred. There were no additional findings during the interviews and assessments. An audit was conducted on all residents for signs of aggressive behaviors and no other residents were identified.<br><br>This Federal Tag relates to Complaint IN00363003.<br><br>3.1-27(a)(1) | | | |
| F 0880<br>SS=E<br>Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable | | | |

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| | 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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP | | | |

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| | and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | | | |
| | Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures for infection control, to prevent or contain the spread of the Covid-19 virus, when the facility failed to ensure staff were wearing face masks when in the common hallways and common areas of the facility for 4 of 4 randomly observed staff members. (CNA 7, Activity Staff 10, QMA 9 and LPN 8)<br><br>Findings include:<br><br>During an observation, on 10/5/2021 at 1:55 p.m., CNA 7 was walking in the South hallway and did not have on a face mask. The MDS (Minimum Data Set) Coordinator indicated the staff had just arrived to work. Activity Staff 10 was walking in the South hallway and had a face shield on with her mask pulled down under her chin with her mouth and nose uncovered.<br><br>During an observation, on 10/5/21 at 2:40 p.m., QMA 9 was at the south nurses station and was preparing a drink for a female resident in a wheelchair. Her face shield was on and her mask was not covering her nose or her mouth. QMA 9 indicated she knew she was not supposed to pull | F 0880 | **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Full house education with staff on residents who are in TBP: signage on each door is posted with PPE requirements.<br>**Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice.<br><br>The DON or designee will complete the following:<br>- Staff involved will be educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. Follow CDC and facility policy.<br>Policy: Use of PPE While In The | 10/11/2021 |

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| | her mask down and she was trying to breathe for a minute.<br><br>During an observation, on 10/5/21 at 2:56 p.m., LPN 8 was walking down the central hallway with her mask under her chin and not covering her mouth or her nose. When the DON was questioned about LPN 8 walking in the hallway without her mask on, the DON instructed LPN 8 to pull her mask up.<br><br>During an interview, on 10//5/21 at 3:21 p.m., the DON (Director of Nursing) indicated she was not sure how CNA 7 was able to enter the building without having a face mask in place.<br><br>During an interview, on 10/5/21 at 4:23 p.m., the ED (Executive Director) indicated the staff were aware of the need to keep their face masks on over their mouth and nose.<br><br>A current policy, titled "Use of PPE While In The Facility," updated 6/23/21 and received from the ED on 10/7/21 at 2:42 p.m., indicated "...All staff must wear a surgical mask at all times, this includes all departments [Nursing, Housekeeping, Dietary, Maintenance, Business Office, Medical Records, HR and Central Supply]...all direct care staff must wear a surgical mask and eye protection at all times...."<br><br>3.1-18(b) | | Facility<br>CDC: PPE sequence<br>AAPACN: Personal-Protective-Equipment-PPE-Donning-and-Doffing-Competency<br><br>**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:**<br>A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON.<br><br>The root cause was identified resulting in the facility's failure.<br><br>Solutions were developed and systemic changes were identified that need to be taken to address the root cause.<br><br>The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate<br><br>**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:**<br>After the IDT and Infection Preventionist completed the RCA | |

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| | | | and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion.<br><br>To ensure Infection Control Practices are maintained, the following monitoring will be implemented.<br><br>1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained.<br><br>Ensure execute proper donning and doffing of PPE, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection, including staff and visitors<br><br>Ensure staff are wearing face masks when in the common hallways and common areas of the facility – covering mouth and nose<br><br>2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and | |

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| | | | complying with the solutions identified in B1 as above. This will occur for 6 weeks and until compliance is maintained.<br><br>Ensure execute proper donning and doffing of PPE, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection, including staff and visitors<br><br>Ensure staff are wearing face masks when in the common hallways and common areas of the facility – covering mouth and nose<br><br>**Quality Assurance and Performance Improvement (QAPI):**<br>The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. | |