STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155157	A. BUILDING 00 B. WING	12/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-RICHMOND	1042 OAK DR RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for a Covid-19 Focused Infection Control Survey. Survey date: December 10, 2020 Facility number: 000077 Provider number: 155157 AIM number: 100266490 Census bed type: SNF/NF: 54 Total: 54 Census payor type: Medicare: 16 Medicaid: 35 Other: 3 Total: 54 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 15, 2020	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint and Focused Infection Control Survey on December 10, 2020 . Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0880 SS=F 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			

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

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	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 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			

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	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 observation, interview, and record review, the facility failed to ensure transmission-based precautions (TBP) were documented as initiated for a resident experiencing symptoms of COVID-19 and a resident with a positive antigen test, ensure personal protective equipment (PPE) was utilized to avoid cross contamination during reuse of gowns, ensure staff wore the appropriate PPE while in resident rooms on TBP, ensure gowns were not stored outside of rooms, and ensure assessment and monitoring of residents for COVID-19 symptoms. This had the potential to affect all 54 residents that reside in the facility. Findings include:	F 0880	Resident B, C, D, E, F Res Identified Resident B no longer resides in facility. Residents C, D, E, and F reside in the facility and have recovered from COVID-19. Others All residents have the potential to be affected. An audit was completed for residents to ensure COVID-19 monitoring is in place. An audit was performed to ensure all residents in Yellow and Red are in TBP. Facility staff were educated on not conserving gowns but utilizing single gown use. All used gowns were discarded prior to the surveyor exiting. CNA 6, 8, 4 and the	01/05/2021

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	1a. The clinical record for Resident B was reviewed on 12/10/20 at 3:05 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, COVID-19, other amnesia, and dementia. A document, dated 11/27/20, identified, by the Director of Clinical Education (DCE), as the resident roster for COVID-19 testing, indicated Resident B was positive for COVID-19 at 11:46 a.m. and, again, at 12:06 p.m., via antigen testing. There were no physician orders to indicate TBP were initiated for Resident B's positive COVID-19 antigen test conducted on 11/27/20. A progress note, dated 11/27/20 at 6:32 p.m., indicated the following, "...Resident wondering [sic] in rooms looking for her husband. When staff tried to redirect resident she then begin [sic] stating that staff was being mean to her. Medications given, resident also treated for pain to rule out increased pain due to resident pacing the halls, resident taken to room, needs meet...." A progress note, dated 11/28/20 at 5:51 p.m., indicated the following, "...Resident beginning to pace back and forth in hallway, ringing hands when standing still, trying to cry out for help and when someone can't respond resident states she is not loved. Anxiety is increased at this time...." A lab document indicated Resident B was tested, again, for COVID-19, via PCR test, on 11/27/20. The results were reported on 11/28/20 and were positive for COVID-19. The progress notes indicated Resident B was transferred to another facility on 11/30/20. There was no indication TBP were in place for		Admission Nurse were educated immediately on TBP with single use gowns and educated on the need to wear a facemask at all times when in the facility, how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection; hand hygiene (hand washing and ABHS) with return demonstration, and when to perform hand hygiene. Education The Corporate Infection Preventionist/designee educated all staff prior to 1.1.2021 regarding isolation precautions, the need to wear a facemask at all times when in facility, how and when to don and doff PPE with return demonstration, hand hygiene with return demonstration, and the need to maintain face covering over the mouth and nose at all times when in use. Staff have been educated on the need for accurate documentation along with transmission based precautions in the medical record. Monitor The Infection Preventionist/designee will audit 5 random staff members regarding how and when to don and doff PPE, hand hygiene and need to maintain face covering over the mouth and nose at all times when in the facility. Audits will occur	

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	Resident B from 11/27/20 to 11/30/20. An interview conducted with Certified Nursing Assistant (CNA) 4, on 12/10/20 at 1:25 p.m., indicated Resident B was positive for COVID-19 while on the long-term care side of the building. She wandered in and out of rooms and didn't like to wear a mask. She didn't know Resident B was positive for COVID-19 until she left the facility but didn't care directly for her. CNA 4 would see Resident B wandering up and down the hallways. An interview conducted with the DCE, on 12/10/20 at 1:50 p.m., indicated Resident B was asymptomatic when the antigen test was conducted on 11/27/20. When a resident is positive for COVID-19, via an antigen test, and is asymptomatic, then we conduct a PCR test and put the resident in TBP. Most of the time nursing staff input orders for TBP but we implement it immediately as a nursing measure. The expectations are for the use of TBP be included in the documentation. Especially in Resident B's case with her pacing the hallways and going in and out of rooms. 1b. A physician order, dated 10/26/20, indicated the following, "...Temp [temperature] and 02 sat [oxygen saturation] BID [twice daily] per co-vid [COVID-19] protocol two times a day for covid precautions...." There were no other physician orders for assessment and/or monitoring of signs and symptoms of COVID-19. 2. The clinical record for Resident C was reviewed on 12/10/20 at 3:10 p.m. The diagnoses included, but were not limited to, left femur fracture, fracture of right ankle, seizures, and		daily for 6 weeks, then weekly for 4 months. Audits will occur on all shifts and units and will include weekend audits. QAPI Audits will be submitted to QAPI monthly for 6 months. 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. **880** Infection Prevention and Control **Res**	

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	schizophrenia. A physician order, dated 10/26/20, indicated the following, "...Temp [temperature] and 02 sat [oxygen saturation] BID [twice daily] covid precautions [sic]...." There were no other physician orders for assessment and/or monitoring for signs and symptoms of COVID-19. Resident C was tested, on 11/27/20, and was negative for COVID-19 via antigen testing. She was also tested on 12/1/20, via antigen testing, and was negative at that time. A progress note, dated 12/7/20, indicated a rapid test was conducted on Resident C and was positive for COVID-19. She was experiencing an elevated temperature. 3a. The clinical record for Resident D was reviewed on 12/10/20 at 3:30 p.m. The diagnoses included, but were not limited to, noninfective gastroenteritis and colitis, diarrhea, COVID-19, and constipation. A physician order, dated 8/29/20, indicated the following, "...TEMP [temperature] and 02 Sats [oxygen saturation] BID [twice daily]...." There were no other physician orders for assessment and/or monitoring for signs and symptoms of COVID-19. 3b. A progress note, dated 12/2/20, indicated a COVID-19 test for Resident D was negative. A progress note, dated 12/4/20 at 8:55 a.m., indicated the following, "SBAR - Change of			

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	Condition...Situation: N/V [nausea and vomiting] and mucous stool...Assessment: Residents stool was yellow and appears as mucous. Res [resident] has a HX [history] of constipation and blockage no HX of Crohn's disease or ulcerative colitis...Response: Resident declines PRN [as needed] zofran [medication to prevent nausea and vomiting]...." There was no indication in Resident D's clinical record that TBP were implemented when he was distributing symptoms of nausea, vomiting, and mucous in his stool. A progress note, dated 12/9/20 at 8:55 a.m., indicated he was in isolation due to COVID-19. 4. The clinical record for Resident E was reviewed on 12/10/20 at 4:19 p.m. The diagnoses included, but were not limited to, cerebral infarction, dysphagia, constipation, and dependence on supplemental oxygen. A physician order, dated 4/24/20, indicated obtain temperature and oxygen saturation twice daily. There were no other physician orders for assessment and/or monitoring for signs and symptoms of COVID-19. A progress note, dated 12/1/20, indicated Resident E tested positive for COVID-19 with the antigen test twice. She was experiencing elevated temperature, joint pain, weakness, and fatigue. 5. The clinical record for Resident F was reviewed on 12/10/20 at 4:22 p.m. The diagnoses included, but were not limited to, myocardial			

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	infarction, respiratory failure, and congestive heart failure. A "Hospital to Post-Acute Care Transfer COVID-19 Assessment" form, dated 11/22/20, indicated Resident F was tested for COVID-19 while at the hospital and was negative, on 11/20/20. She was admitted to the facility on 11/22/20. A document, dated 11/27/20, identified, by the Director of Clinical Education (DCE), as the resident roster for COVID-19 testing, indicated Resident F was positive for COVID-19 via antigen testing. A physician order, dated 12/2/20, indicated temperature and oxygen saturation to be obtained twice daily for COVID-19 monitoring. There were no other physician orders for assessment and/or monitoring for signs and symptoms of COVID-19 from 11/22/20 to 12/7/20. A physician order, dated 12/8/20, indicated the following, "...COVID-19 - Monitor for fever, feeling feverish/chills, cough, shortness of breath/difficulty breathing, fatigue [tiredness] sore throat, runny or stuffy nose, muscle pain, body aches, headache, nausea, diarrhea, loss of taste/sense of smell. Record temp [temperature], lung sounds and biox [oxygen saturation] daily. Notify provider of temp > [greater than] 100.0 and/or biox [oxygen saturation] < [less than] 90% and/or any other symptoms listed above...." An interview conducted with the DCE, on 12/10/20 at 2:40 p.m., indicated she noticed the orders for temperature and oxygen saturation			

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	were not complete for the monitoring and assessing of COVID-19. She increased the monitoring to twice daily for the yellow zone, three times daily for the red zone, and increased what the nursing staff are looking at related to signs and symptoms of COVID-19. She provided an example of such order and it indicated the following, "...COVID-19 - Monitor for fever, feeling feverish/chills, cough, shortness of breath/difficulty breathing, fatigue [tiredness] sore throat, runny or stuffy nose, muscle pain, body aches, headache, nausea, diarrhea, loss of taste/sense of smell. Record temp [temperature], lung sounds and biox [oxygen saturation] daily. Notify provider of temp >100.0 [greater than 100.0] and/or biox <90% [less than 90%] and/or any other symptoms listed above. Every shift for COVID-19 monitoring...." A document titled "COVID-19 LTC [Long Term Care] Facility Infection Control Guidance Standard Operating Procedure", updated 11/19/20, indicated the following, "...PREVENT THE INTRODUCTION OF COVID-19 INTO YOUR FACILITY...Assess residents' symptoms of COVID 19 infection upon admission to the facility, and daily during this pandemic and implement appropriate infection prevention practices for incoming symptomatic residents...People with these symptoms may have COVID-19:...Fever or chills... Cough... Shortness of breath or difficult breathing...Fatigue...Muscle or body aches...Headache...New loss of taste or smell...Sore throat...Congestion or runny nose...Nausea or vomiting...Diarrhea...PREVENT THE SPREAD OF COVID-19 WITHIN YOUR FACILITY...Monitor residents and employees for fever or respiratory symptoms...." A document titled "Preparing for COVID-19 in			

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	Nursing Homes" from the Centers for Disease Control and Prevention (CDC), updated 11/20/20, indicated the following, "...Evaluate and Manage Residents with Symptoms of COVID-19...Actively monitor all residents upon admission and at least daily for fever...and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation...If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below...Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator...eye protection...gloves, and gown...." 6a. An observation of the facility was conducted on 12/10/20 at 12:00 p.m. The following was noted: An isolation gown hanging on a chair outside of the room 53, An isolation gown hanging from the medication cart, facing West, by the LTC Hallway nurses' station, & An isolation gown was hanging in the railing outside of the service hallway where laundry is located. Another observation of the facility was conducted on 12/10/20 at 12:30 p.m. The following was noted: An isolation gown was still hanging on a chair outside of room 53, An isolation gown was still hanging from the medication cart at the LTC Hallway nurses' station, An isolation gown was hanging on railing outside of room 48,			

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	An isolation gown was hanging behind the door, on the inside, in room 52, An isolation gown was still hanging on the railing outside of the service hallway where laundry is located, & A used washcloth was located on top of the isolation cart outside of room 34. Another observation of the facility was conducted on 12/10/20 at 4:45 p.m. The following was noted: An isolation gown was still hanging on a chair outside of room 53, A used washcloth was located on top of the isolation cart outside of room 34, & An isolation gown was still hanging on the railing outside of the service hallway where laundry is located. 6b. An observation was conducted, on 12/10/20 at 5:00 p.m., of CNA 6 and CNA 8 located inside of room 32 with a resident. Room 32 was deemed as "yellow" and on TBP. CNA 6 did not have a gown on and was in close contact with that resident. CNA 8 opened the door and walked outside of room 32, while wearing her gown, gloves, mask, and face shield, and proceeded to pick up a folded towel from the clean linen cart and went back into room 32. Another observation was conducted, on 12/10/20 at 5:08 p.m., of CNA 8 answering a call light in room 30 with no donning of a gown prior to entry. Room 30 was deemed as "yellow" and on TBP. An interview conducted with DCE, on 12/10/20 at 11:50 a.m., indicated "there is plenty of PPE". The facility are utilizing single use gowns and no			

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	reuse should be occurring. An interview conducted with the Admissions Nurse, on 12/10/20 at 12:28 p.m., indicated the CNAs that are working down a specific hallway are hanging their gowns on the inside of the door for reuse. An interview conducted with CNA 4, on 12/10/20 at 1:25 p.m., indicated certified nursing assistants put a gown on the inside of the door for reuse of PPE. We utilize 1 gown per staff member for both residents if it's in a semiprivate room. An interview conducted with DCE, on 12/10/20 at 3:00 p.m., indicated the expectations are for the facility staff to follow the Centers for Disease Control and Prevention (CDC) and State Guidelines for the use of PPE in certain zones of the facility. This includes "green", "yellow" and "red" zones. A document titled "COVID-19 LTC [Long Term Care] Facility Infection Control Guidance Standard Operating Procedure", updated 11/19/20, indicated the following, "...Unknown COVID-19 status [Yellow]: All residents in this category warrant transmission based precautions [droplet and contact]. HCP [healthcare personnel] will wear single gown per resident, glove, N095 mask and eye protection [face shield/or goggles]. Gowns and gloves should be changed after every resident encounter with hand hygiene performed...." A policy titled "Transmission Based Precautions", undated, was provided by the DCE on 12/10/20 at 12:47 p.m. The policy indicated the following, ""..."Transmission-based			

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	precautions" are a group of infection prevention and control practices that are used in addition to standard precautions for residents who may be infected or colonized with infectious agents that require additional control measures to prevent transmission effectively. There are three categories of transmission-based precautions: contact, droplet, and airborne...2. Initiation of Transmission-Based Precautions...b. An order for isolation will be obtained for residents who are known or suspected to be infected or colonized with infectious agents that require additional controls to prevent transmission effectively...c. The order for isolation will specify the type of isolation and reason for isolation. The duration will depend upon the infectious agent or organism involved...Contact Precautions...c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that my involve contact with the resident or potentially contaminated areas in the resident's environment...Droplet Precautions...d. Healthcare personnel wear a mask for close contact with infectious resident...." 3.1-18(a) 3.1-18(b)(1)(A)			
F 0886 SS=F 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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GOLDEN LIVING CENTER-RICHMOND	1042 OAK DR RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 interview and record review, the facility failed to ensure staff testing for COVID-19 was conducted and documented based on the county positivity rate that warranted the need for twice weekly testing. This had the potential to affect all 54 residents that reside in the facility. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) test positivity rates archive, on 12/11/20 at 10:50 a.m., indicated the following positivity rates for Wayne County: 10/21/20- 8.3%, 10/28/20- 12.7%, 11/4/20- 13.5%, 11/11/20- 12.4%, 11/18/20- 14.3%, 11/25/20- 14.7% & 12/2/20- 15.1%	F 0886	All residents. Res Identified All residents have the potential to be affected. Others All residents have the potential to be affected. The facility failed to ensure staff testing for COVID-19 was completed and documented based on the county positivity rate and needing testing twice weekly. An ADHOC QAPI was completed and the DCE/designee updated and completed the line listing appropriately. Education The Infection Preventionist/designee provided education to staff on how to monitor county positivity rate along with testing requirements. Education provided to Medical	01/05/2021

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	A document titled "COVID-19 Testing", dated 11/19/20, was provided by the Director of Clinical Education (DCE) on 12/10/20 at 4:15 p.m. It had a list of all staff that are employed at the facility and indicated all staff were tested on 11/19/20. A document titled "COVID-19 Testing", dated 11/24/20, indicated all staff were tested on that date. A document titled "COVID-19 Testing", dated 11/27/20, indicated all staff were tested on that date. A document with no title, dated 12/1/20 and 12/3/20, indicated all staff were tested but unsure of exact dates of testing. A document with no titled, dated 12/8/20, indicated all staff were tested on that date. An interview conducted with DCE, on 12/10/20 at 1:50 p.m., indicated she arrived at the facility on 12/8/20 to assist. They had conducted staff and resident testing and noted positive results for both staff and residents. The previous facility staff were only marking staff and residents, on the line listing, that were positive. She was unable to locate any previous staff testing prior to 11/19/20. She explained to the facility they need to utilize the line list for all staff and residents, not just ones that are positive. Prior to the DCE arriving, on 12/8/20, the facility was printing off employee and resident rosters with names and documenting positive or negative results on those rosters. The DCE has instructed the facility staff to fill out the line listing with their names and any signs and symptoms. The		Records on how to maintain line listing for staff and residents. Monitor The Infection Preventionist/designee will monitor the county positivity rate weekly and will inform Administrator and Medical Records of rate. Medical Records will maintain line listing of staff and residents. The line listing will be monitored after each testing date per the county positivity rate for 6 weeks until compliance is maintained. QAPI Audits will be submitted to QAPI monthly for 6 months to ensure increased compliance and will adjust audits accordingly. **886** COVID-19 Testing-Residents & Staff **Res**	

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	facility staff will go back and document the employees' results after testing was conducted. 3.1-18(a) 3.1-18(b)(1)(A)			