STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 00 B. WING	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE HEALTH AND REHABILITATION CENTER	3114 EAST 46TH STREET INDIANAPOLIS, IN 46205

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F 0000 Bldg. 00	This visit was for a Covid-19 Focused Infection Control Survey. Survey date: December 6, 2021 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Census bed type: SNF/NF: 113 Total: 113 Census payor type: Medicare: 11 Medicaid: 88 Other: 14 Total: 113 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 10, 2021	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for 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

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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	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 properly prevent and/or contain COVID-19 regarding staff not donning appropriate Personal Protective Equipment (PPE) while in a resident's room that was in transmission precautions, or wearing appropriate eye protection during an activity that was within 6 feet of a resident for 2 of 2 random observations observed, and staff not screening upon entering in the facility. This had a potential to affect 113 of 113 residents that reside in the facility. (Resident F and G) Findings include: 1. An observation was made of the time clock with Certified Nursing Assistant (CNA) 6 on 12/6/21 at 2:00 p.m. The time clock was located on a wall in a hallway near the kitchen area by a	F 0880	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. A screening station has been set up at the entrance by the time clock. Staff have been educated to enter through one of 4 doorways and screen immediately upon entering. Therapist 11 was re-educated on the PPE policy. Activity assistant 9 was re-educated on the PPE policy. 2. All residents have the potential to be affected. A screening station has been set up at the entrance by the time clock. Staff have been educated to enter through one of 4 doorways and	12/28/2021

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	door to the outside of the facility. There was no observation of screening materials for staff to screen for sign and symptoms of COVID-19 on arrival to the facility. An interview was conducted with CNA 6 at 2:05 p.m. She indicated there were three locations for nursing staff to screen for signs and symptoms of COVID-19 prior to working on the floor. The nursing staff was able to screen at the 300 hall nurse's station, 100 hall nurse's station and/or the front lobby. She normally enters the facility using the door by the time clock and clocks in for her shift. After, she walks through the facility to the 100 hall nurse's station, and at that time she screens for signs and symptoms of COVID-19. An interview was conducted with Registered Nurse (RN) 7 at 12/6/21 at 1:54 p.m. She indicated she screened for signs and symptoms of COVID-19 at the 100 hall nurse's station. She first entered the facility and clocked in at the time clock. She then walked to the 100 hall nurse's station to screen for signs and symptoms of COVID-19. That was a normal routine for her. An interview was conducted with Housekeeper 8 on 12/6/21 at 1:40 p.m. She indicated she screened daily for signs and symptoms of COVID-19 in the laundry room. She entered the facility using the door by the time clock and clocked in for her shift. She then walked to the breakroom to use her locker. After, she walked through the 200 hall to the laundry room. At that time, she screened for signs and symptoms of COVID-19. An interview was conducted with License Practical Nurse (LPN) 5 on 12/6/21 at 1:13 p.m.		screen immediately upon entering. Therapist 11 was re-educated on the PPE policy. Activity assistant 9 was re-educated on the PPE policy. 3. The policies on PPE and the COVID-19 LTC Facility Infection Control SOP were reviewed and remain appropriate. Facility staff have been re-educated on these policies. Therapy and activity staff will complete PPE Donning/Doffing competencies. The DON or her designee will complete random observations daily to ensure staff are screening in immediately upon entering the facility and to ensure staff are donning/doffing appropriate PPE upon entering/exiting an isolation room for 6 weeks and until 100% compliance is achieved; then weekly for 5 months to ensure compliance is maintained. The Activity Director or her designee will complete random observations daily for 6 weeks during activities to ensure appropriate eye protection is worn during activities for 6 weeks and until 100% compliance is achieved, then weekly for 5 months to ensure compliance is maintained. 4. The findings of these observations will be presented during the facility's monthly QAPI meetings and the plans of action adjusted accordingly.	

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	She indicated her normal routine on arrival to the facility was to enter the door where the time clock was located and clock in. She then returns back to her car and drives around the building to enter the door located on the 300 hall. After, LPN 5 then walks through the 300 hall to the front lobby. At that time, she screens for signs and symptoms of COVID-19. An interview was conducted with the Director of Nursing (DON) on 12/6/21 at 3:22 p.m. She indicated staff should be screening for signs and symptoms of COVID-19 on arrival. 2. The clinical record for Resident F was reviewed on 12/6/21 at 11:15 a.m. The resident's diagnosis included, but was not limited to, heart failure. A physician order dated 11/30/21 indicated Resident F was to be placed in transmission precautions for 14 days. An observation was made of Resident F on 12/6/21 at 11:21 a.m. Resident F's room was observed from the hallway with a contact transmission precaution sign on wall by the door frame and a PPE cart was sitting next to door. The transmission signage on the door indicated anyone entering Resident F's room was to don a mask/N95 respirator, eye protection, gown and gloves. At that time, Resident F was observed lying in bed, and Physical Therapist (PT) 11 was standing at the resident's bedside speaking with him. PT 11 was observed wearing a N95 respirator and a faceshield, but had not donned on a gown or gloves prior to entering the room. An interview was conducted with PT 11 on 12/6/21 at 11:25 a.m. He indicated Resident F		DIRECTED PLAN OF CORRECTION- Creekside Health and Rehabilitation 3114 East 46th Street Indianapolis, IN 46205 Survey Date December 6, 2021 Survey Event ID 9F8K11 Deficiency F 880 The facility failed to properly prevent and/or contain the potential spread of COVID-19 by one therapy staff member not donning PPE when entering an isolation room, one activity assistant not wearing protective eyewear when providing nail care for a resident and staff not immediately screening for COVID upon entering the facility. **Root cause analysis** **Finding 1:** What: 2 staff not wearing necessary PPE. Why: The therapist stated it was because he did not know the resident was in isolation, disregarding posted signage indicating so. The activity assistant stated her face shield wouldn't stay on her head. Immediate corrective action: Staff were immediately re-educated. **Finding 2:** What: Staff not immediately screening for COVID upon entrance to the facility. Why: Most stated it was because	

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	did have a transmission signage by his door, but he was unaware Resident F was in isolation. An interview was conducted with the Administrator in Training (AIT) on 12/6/21 at 11:31 a.m. She indicated Resident F was in isolation, and PPE was to be worn while in the resident's room. 3. The clinical record for Resident G was reviewed on 12/6/21 at 11:30 a.m. The resident's diagnosis included, but was not limited to, type 2 diabetes. An observation was made of Resident G in activities on 12/6/21 at 11:30 a.m. Resident G was observed sitting at a table receiving a manicure by Activities Assistant (AA) 9. During that time, AA 9 was observed with a surgical mask and eyeglasses on while providing the nail care to Resident G. An interview was conducted with AA 9 on 12/6/21 at 11:40 a.m. She indicated she had not donned a facesheild while she was within 6 feet of Resident G, because it would not stay on her head. The "COVID Data Tracker" from The Centers for Disease Control and Prevention at Covid.CDC.gov, was retrieved on 12/7/21. It indicated Marion county's community COVID-19 positivity rate was 12.65%. The Personal Protective Equipment (PPE) policy was provided by the Nurse Consultant on 12/6/21 at 3:30 p.m. It indicated "..Policy: It is the policy of this facility to ensure PPE is available to staff, residents and visitors as needed; and they understand when and how to use the PPE		there was no place to screen in by the time clock/back door. Immediate corrective action: A screening station was added at the back door right by the time clock so staff entering through this door can immediately screen upon entering the facility. Staff were re-educated on the screening process. **Corrective measures** Reeducation and inservices with staff including: Therapy and activities staff re-education on PPE use. Re-education for facility staff on the COVID screening process. Summary: Root cause analysis determined the need for daily observations and continual re-education by the IP/DON/facility administration related to both COVID screening completion and PPE usage. Continued non-compliance will result in disciplinary action and possible termination to protect residents and staff. Competencies on donning/doffing PPE will be completed with therapy and activities staff. Daily rounding, varying shifts and days, will be conducted by the DON/IP/designee to continue for a period of six weeks and until 100% compliance is achieved then weekly for a period of at least 6 months and compliance is maintained to be determined by	

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	...Purpose: To prevent transmission of infectious illnesses or pathogens ...Procedure: ...8. When a resident requires isolation precautions, the required PPE will be located on the residents isolation sign. 9. Staff will follow the policy for isolation precautions and the use of PPE ..." The COVID-19 LTC [Long Term Care] Facility Infection Control Guidance Standard Operating Procedure (SOP) dated 9/28/21 indicated, "...Screening: Screen all persons who enter the facility; (e. g. visitors, vendors and HCP [Healthcare Personnel]) for signs and symptoms of COVID-19 (e.g., questions about and observations of signs or symptoms) and deny entry to those with COVID-19 diagnosis, signs or symptoms, or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status) ...Continue universal source controls ...eye protection for HCP when delivering care within 6 feet of the resident: ..." The SOP indicated a resident placed in contact transmission precautions [yellow zone] staff should don on N95 respirator, eye protection, gown, and gloves. 31-18(b)		the QAPI Committee. The Facility LTC infection control self-assessment was reviewed with the regional IP it was agreed that it is an accurate assessment of the facility. Survey findings, root cause analysis reviewed with regional IP, Medical Director, Administrator, facility IP, and Director of Clinical Services. The plan of action was agreed upon. *Please note: The facility has made contact with the QIO. A virtual meeting has been scheduled and some additional educational material provided. Moving forward, we are working collaboratively with them to make further improvements.*	
F 0886 SS=E 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 interview and record review, the facility failed to ensure an unvaccinated staff member was tested for Covid-19 immediately upon symptoms, body aches, and did not continue to work while experiencing symptoms for 1 of 3 staff members reviewed for Covid-19 testing with the potential to affect 24 of 24 residents on the 300 hall. (LPN-Licensed Practical Nurse 5) Findings include: An entrance conference was conducted with the NC (Nurse Consultant,) DON (Director of Nursing,) and AIT (Administrator in Training) on 12/6/21 at 10:45 a.m. During the conference, the NC indicated they had 9 Covid-19 positive residents and 1 Covid-19 positive staff member during the current outbreak. The staff member was LPN 5, who was not vaccinated against Covid-19. LPN 5 developed a headache one day while at work, so she tested herself for Covid-19 via a rapid test and tested negative, so she	F 0886	The facility will ensure this requirement is met through the following corrective measures: 1. The resident recovered from COVID. The employee has recovered from COVID. 2. All residents have the potential to be affected. See below for corrective measures. 3. The COVID-19 LTC Facility Infection Control SOP was reviewed and remains appropriate. Facility staff will be re-educated on this policy. The DON or her designee will complete daily random observations to ensure staff are screening in immediately upon entering the facility, reporting symptoms immediately, testing immediately and leaving the facility pending the results of	12/28/2021

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	remained at work the remainder of her shift. The next day, while at work, LPN 5 was feeling fatigued, so she tested herself again, and it came back positive for Covid-19. They conducted contact tracing for potential resident exposure, but LPN 5 informed that she did not have contact with any residents without the proper PPE (personal protective equipment) for over 15 minutes, however, the first resident to test positive for Covid-19 during this outbreak was located on the hall in which LPN 5 worked, the 300 hall, and 5 additional residents on the 300 hall had tested positive since. An interview was conducted with the NC and DON on 12/6/21 at 12:14 p.m. The NC indicated a headache alone would not warrant sending a staff member home for Covid-19 symptoms. The next day, when LPN 5 was feeling fatigued, she tested herself, and informed her shortly after of the positive result, and left the facility right away. The DON indicated LPN 5 worked at the facility for 3 hours that day prior to testing positive for Covid-19. The time sheet for LPN 5 was provided by the NC on 12/16/21 at 1:45 p.m. It indicated she worked on 11/18/21 from 2:51 p.m. until 10:53 p.m. and on 11/19/21 from 5:48 p.m. until 8:20 p.m. An interview was conducted with LPN 5 on 12/6/21 at 1:13 p.m. She indicated she worked the evening shift (2:30 p.m. to 10:30 p.m.) on 11/18/21 and developed a headache in the middle of her shift. She tested herself for Covid-19 twice and was negative both times. She took some Tylenol and it alleviated her headache. She didn't have any preexisting conditions that made her prone to headaches, and stated, "I would say I		those tests if symptomatic for 6 weeks, then weekly for 5 months to ensure compliance is maintained. 4. The findings of these observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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intermittently get headaches." She informed the DON after testing negative that day of her headache and negative tests. She came into work the following day on the evening shift of 11/19/21 "with slight body aches when I arrived....I had mild body aches before I left home, but thought my body was just tired from working, so I didn't think 'Oh no I have body aches and shouldn't go to work.'" She wanted to make sure, so she tested herself while at work. She regularly screened for signs and symptoms of Covid-19 when she came to work, but didn't recall what she put on the screening form on 11/19/21.

The 11/18/21 and 11/19/21 screening forms for LPN 5 were provided by the DON on 12/6/21 at 3:10 p.m. Both forms were completed as indicating she was not currently ill, did not have any new symptoms not caused by a preexisting condition, and no symptoms including fever, cough, shortness of breath, sore throat, diarrhea, nausea/vomiting, loss of taste/smell, body aches, or headache.

An interview was conducted with the NC on 12/6/21 at 2:15 p.m. She indicated she was unaware LPN 5 had body aches on 11/19/21 or that she had them prior to coming to work. If she had known that, she probably would have told her to not come in that day.

The 11/19/21 Covid-19 Rapid Test Reporting Form for LPN 5 was provided by the DON on 12/6/21 at 3:09 p.m. It indicated she tested positive via a rapid test on 11/19/21 at 8:00 p.m.

On 12/6/21 at 3:47 p.m., the DON provided the 11/19/21 census report for the facility. It indicated 24 residents on the 300 hall, 6 of

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	whom tested positive for Covid-19 since 11/21/21. On 12/6/21 at 3:11 p.m., the DON provided a list of unvaccinated employees that included LPN 5. The Covid-19 Testing of Staff and Residents policy was provided by the NC on 12/6/21 at 12:14 p.m. It read, "Staff with symptoms or signs of Covid-19, vaccinated or not vaccinated, must be tested immediately and are expected to be restricted from the facility pending the results of Covid-19 testing.			