STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 00 B. WING	09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00362059 and IN00363035. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00362059 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00363035 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: September 27, and 28, 2021 Facility number: 000376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 9 Medicaid: 35 Other: 11 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 6, 2021.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint IN00362059 and COVID 19 Focused Infection Control Survey on September 28, 2021. Please accept this plan of correction as the provider's credible allegation of compliance. We respectfully request a desk review	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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

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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure medication was not left on the floor, and disposed of properly for 1 of 1 random observations on the secured Memory Care Unit. Findings include: On 9/28/21 at 12:15 p.m., a large, oblong, white pill was observed on the floor of the memory care unit hallway. A second, smaller capsulated pill, with clear coating and a brown substance inside, was also observed on the floor of the same hallway. Resident FF independently ambulated out of his room in his wheelchair and came to a stop between the two pills on the floor. There was no nurse on the unit to notify. On 9/28/21 at 12:16 p.m., a third small, circular, white pill was observed on the floor beside a trash can at the locked memory care unit door. A forth white tablet pill was observed in a cup that was inside of the trash can. There was no nurse on the unit to notify. On 9/28/21 at 12:33 p.m., the Director of Nursing (DON) observed the three pills on the floor and the fourth pill in the trash can. She picked up the first pill by the trash can and indicated she did not know what the medication was, and dropped the	F 0689	**F689 – Free of Accident Hazards/Supervision/Devices** It is the practice of this facility to ensure the resident environment is free of accidents and hazards. Residents who reside in the facility have potential to be affected by this finding; however, no residents were affected. All nurses and QMAs were educated on the proper procedure for disposal of medications by the DON. The Memory Care unit will be checked to ensure there is no medication on the floor and that medications are being destroyed properly. Audit will be done by the ADON or designee five times a week x 4 weeks, then three times a week x 4 weeks, then weekly x 4 weeks, then monthly thereafter x 3 months. The results of the audits will be submitted to the QAPI committee weekly and then monthly as indicated. Any patterns will be identified. If	10/27/2021

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	pill into the trash can. She lifted the plastic trash can liner and picked up the other pills from the floor. The DON indicated she did not know what those pill were either. She dropped the pills into the plastic trash bag, tied the bag with a knot, and placed the bag into the already full trash can on the nurses medication cart. No attempt was made to identify the pills. During an interview on 9/28/21 at 1:50 p.m., the Administrator (ADM) indicated, the facility did not have a policy to address disposal of medication found on the floor, but pills that were found on the floor should be disposed of in the "sharps/bio." During the survey exit conference on 9/28/21 at 3:30 p.m., the DON indicated she put the pills in a trash bag and threw it away on the nurses' medication cart trash can. Later, the nurse had taken the trash out to the dumpster, and that was "okay" because the pharmacist said the pills could be thrown in the trash. The DON indicated she had not identified what the medications were, but knew they were not narcotics by the look of them. 3.1-45(a)		needed, the QAPI committee will write an Action Plan. Any Action Plan will be monitored by the Administrator weekly until resolved.	
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			

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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 appropriate infection control practices were implemented while the facility was in outbreak testing to prevent the potential for the spread of the novel Coronavirus COVID-19 virus during a global pandemic when the facility failed to ensure staff wore appropriate PPE (personal protective equipment) while in isolation rooms, failed to ensure staff performed proper PPE donning/doffing, failed to ensure staff completed hand hygiene at appropriate times, and failed to encourage residents in isolation to remain in their rooms for 1 of 1 day of observations. Findings include: On 9/28/21 at 9:50 a.m., Resident W was observed as she independently exited her room in her wheelchair. Her door was marked with a sign that	F 0880	**F 880 – Infection Prevention & Control** It is the practice of this facility to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease. All residents residing in the facility have the potential to be affected; however, no resident was affected. At an in-service for all staff held on 10/14/2021 and conducted by DON/Designee, the following was reviewed: A.) How and when	10/27/2021

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	indicated "Yellow" room for droplet precautions. The Resident did not wear a mask and continued up the hall and went down the 300 hall. On 9/28/21 at 9:55 a.m., the Administrator (ADM) stopped Resident W near the central nurses' station. The ADM greeted Resident W. The ADM leaned down and asked how Resident W was doing and remarked at the "bucket of goodies" she had on her lap. The ADM wore a surgical mask and a face shield. The ADM did not encourage Resident W to return to her room, or to wear a mask. On 9/28/21 at 9:57 a.m., the Maintenance Supervisor entered the secured memory care unit. He indicated to a visitor they could not enter any resident room without proper PPE. The Maintenance Supervisor continued down the hall and stopped outside of Resident N and CC's room. He put on a blue, single-use, isolation gown. He did not tie the gown. He did not sanitize his hand or don a pair of gloves. He did not don a N95 mask. He wore a surgical mask and a face shield. He asked the residents if their remote control was broken, picked up the remote and tested it on the T.V. When the remote worked, the Maintenance Supervisor indicated the remote was fine, it must be the next room. The Maintenance Supervisor exited Resident N and CC's room without doffing his isolation gown or sanitizing his hand after he touched the remote. He immediately entered Resident X and M's room. He did not don an N95 or gloves. He got on his hand and knees and began to work on something under Resident X's bed. During an interview on 9/28/21 at 10:25 a.m., the Infection Preventionist (IP) indicated the whole facility was considered a "Yellow" zone because		to donn and doff PPE with return demonstration, including but not limited to, mask, respirator devices, gloves, gown, and eye protection. B.) Hand Hygiene C.) Importance of encouraging residents in isolation to remain in their rooms. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated. Newly hired staff will receive the in-servicing prior to working. This will be tracked and documented by the Administrator/D.O.N/Designee. A Root Cause Analysis was conducted by the Infection Preventionist, Administrator, Nurse Consultant, and the Medical Director to determine the Root Cause of the facility's Infection Control Citation. The facility has an opportunity to improve its education, and to ensure that all staff has adequate knowledge of the facility's infection control practices, related to Covid-19 and PPE usage. Reviewed and updated the LTC infection control assessment. Three random employees will be audited daily to ensure proper donning and doffing of PPE as well as hand hygiene by the IP nurse/DON/Designee for 6 weeks and until compliance is maintained. Then three random	

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	they were in outbreak testing after two staff members tested positive for COVID-19. This meant staff should be donning full PPE which included an N95 respirator face mask, a full face shield or eye protection, an isolation gown, staff should perform hand hygiene before entering and after exiting any room, and gloves should be worn in isolation rooms. One staff member tested positive on 9/17 and they had worked on the 300 hall. The second staff member had tested positive just a couple days prior on 9/26 and had worked across the whole building, which is why the whole building was considered yellow. Staff should encourage residents to remain in their rooms, and communal dining and activities had been suspended. On 9/28/21 at 10:30 a.m., the Director of Nursing (DON) indicated it was difficult for the nursing staff to pass medications with the isolation gowns and asked if the staff really needed to put new ones on for each room. When asked what the facilities policy was for entering/exiting isolation rooms, the DON indicated staff should have been changing PPE before each room. On 9/28/21 at 11:35 a.m., Resident Y was observed as he independently exited his room in his wheelchair. His door was marked with a sign that indicated "Yellow" for droplet precautions. He continued up the hall and exited the 100 hall. At this time a visiting Psychologist exited Resident Y's room. She indicated she had just finished an admission assessment for Resident Y. He was on droplet isolation as a precaution because he was newly admitted. The Psychologist wore two surgical masks and a face shield. On 9/28/21 at 11:40 a.m., Certified Nursing Assistant (CNA) 18 exited Resident H's room and		employees will be audited three times weekly x 4 weeks and then weekly x 4 weeks. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified. This will occur for 6 weeks and until compliance is maintained. Any concerns will be addressed if found. Results of the monitoring will be presented to the QAPI committee weekly at the QAPI meetings, then monthly when appropriate. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored weekly by the Administrator until resolved.	

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	still wore her isolation gown. She removed a pair of gloves and threw them away in a trash can that sat in the hall. She wore only a surgical mask and face shield. She walked up the hall and indicated to the nurse she needed help with Resident H's wound vac. She paced the hall and tapped her bare hands against the isolation gown on her legs. She entered Resident H's room and did not sanitize her hands or don new gloves. On 9/28/21 at 11:45 a.m., Qualified Medication Aid (QMA) 19 donned an isolation gown but entered DD and BB's room without donning an N95. On 9/28/21 at 11:47 a.m., Resident Y independently ambulated his wheelchair down the 300 hall and entered Resident H's room. Resident Y did not wear a mask and was not encouraged to return to his room. On 9/28/21 at 11:52 a.m., Resident Y exited Resident H's room and passed Resident BB in the hall. Resident BB did not have a mask on. On 9/28/21 at 12:07 p.m., during a lunch observation, CNA 15 was observed as he passed lunch trays on the "Yellow Zone" 100 hall. He donned an isolation gown, pulled his glasses off, and used the outside of the isolation gown to wipe his glasses. He rubbed his eye with the back of his finger, replaced his glasses and continued to prepare the tray. On 9/28/21 at 12:17 p.m., CNA 20 donned an isolation gown, but did not sanitize her hand before she entered Resident FF's room. She indicated she needed to change the sheets on his bed, and Resident FF asked her to help him pull his pants up. Resident FF did not wear a face mask, and CNA 20 wore only a surgical mask and			

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	face shield. During an interview on 9/28/21 at 3:03 p.m., the IP indicated, the ADM should notify ancillary staff about the covid status of the building and the PPE requirements. The visiting Psychologist should have worn a N95 mask, two surgical masks did not replace the effectiveness of a N95. During an interview on 9/28/21 at 3:11 p.m., the Maintenance Supervisor indicated the building was in "lock down" because two staff tested positive. All staff should have worn an isolation gown, gloves, an N95 mask, face shield, and foot covering to enter resident rooms. PPE was especially important for him and needed to be changed before every room because he had to literally get on the floor a lot of the times, so he was always rubbing up against everything. On 9/28/21 at 3:15 p.m., the IP provided a copy of the sign which was posted on every resident's door for droplet precautions instructions. The sign indicated: "Yellow Zone Transmission Based Precautions, Contact Droplet, PPE required: N95 Mask- Approved KN95, Universal eyewear: Face shield or Goggles, Single Gown- with each encounter, gowns must be single use per resident, gloves (hand hygiene donning/offing)...." During the Focused Infection Control survey entrance conference on 9/28/21 at 10:25 a.m., the IP provided a copy of current facility policy titled, "Infection Control: COVID-19 Prevention, Visitation, Surveillance & Education Guidelines," dated 3/15/20. The policy indicated, "...Prevention. Per CDC [Centers for Disease Control] the best was to prevent infection of COVID-19 is avoidance of virus. The most common preventative precautions include appropriate			

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	hand hygiene, avoiding close contact with persons that present with respiratory illness through social distancing and appropriate PPE usage, avoid excessive hand to face/mouth/eyes touching...." The CDC Guidance, dated 3/29/21, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes indicated, " ...The virus is thought to spread mainly between people who are in close contact with one another [within about 6 feet] through respiratory droplets produced when an infected person coughs or sneezes. It may also be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes...HCP [Healthcare Professionals] working in areas with minimal to no community transmission should continue to adhere to Standard and Transmission-Based Precautions based on anticipated exposures and suspected or confirmed diagnoses. This might include use of eye protection, an N95 or equivalent or higher-level respirator, as well as other PPE. In addition, universal use of a well-fitting facemask for source control is recommended for HCP if not otherwise wearing a respirator ...." 3.1-18(b)(1)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, and interview, the facility failed to maintain a safe, clean, and sanitary	F 0921	**F 584 – Safe/Clean/Comfortable/Homel**	10/27/2021

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	environment on 3 of 3 hallways (100, 200 and 300) observed for cleanliness. Findings include: On 9/27/21 at 10:05 a.m. during the initial facility tour, the following was observed: a. The front entrance reception area tiled floors had dirt and paper debris observed on the floor. Trash was observed scattered on the floor near a trash can beside the reception desk. b. The front dining/conference room table was littered with food crumbs, the carpet with food and paper debris, a paper clip, and the wooden base boards with clumps of black soil. c. Observation of the hallway leading from the front door to the main nurses' station was littered with debris to include food items, straw paper, and plastic. The floor in front of the nurses' station was sticky with an unidentified dark substance. There was a puddle of unidentified clear liquid approximately 2 foot in length in front of the nurses' station. d. An area of a spilled, dried dark substance approximately 4 feet in length near the entry of the 300 hallway. The tiled hallway floors were observed to be dirty, sticky to walk on, and littered with dirt clumps, dust bunnies, smashed food, and salt/pepper packets. On 9/27/21 at 10:20 a.m., observation of the floors in the common areas around the main nurses' desk, main dining room, chapel, and therapy room did not appear to have been swept or mopped recently, all heavily soiled with dirt and paper debris. There was no observation of housekeeping working in those areas. On 9/27/21 at 10:22 a.m., the Maintenance Supervisor was observed mopping near the exit of		**ike Environment** It is the practice of this facility to ensure all residents reside in a homelike environment that is safe, comfortable, and clean. The following policies were reviewed: 1) General Cleaning of Resident Room – Clean; 2) Hard Floor Care – Wet/Damp Mop 3) and Homelike Environment. All residents that reside in the facility have the potential to be affected by this finding; however, no resident was affected. Three housekeepers have been hired and Alpha Home AWC continues to interview and hire. All staff was educated on proper handling of soiled lined, cleaning up spills, and completing a maintenance work orders by the DON and Administrator. Housekeeping department was educated on cleaning of rooms and public areas and floor care by the Administrator. Administrator and Department Managers will make rounds to check rooms and public areas and address any concerns as they arise. Audits will be completed 5 times a week for 4 weeks; then 4 times a week for 4 weeks; then 3 times a week for 4 weeks; then 2 times a week for 4 weeks; then 1 time a week for 4 weeks. The results of the audits will be submitted to the QAPI committee weekly and then monthly as indicated. Any patterns will be identified. If	

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	the 100 hallway. On 9/27/21 at 10:35 a.m. during the tour of the 300 hallway, the following was observed: a. Room 301 tiled floor was littered throughout with dirt and food, clumps of mud near the door to the hallway, an unidentified sticky substance tracked into the room, and an unidentified red substance dried on the floor under the tray table of the bed nearest to the window. The bathroom was observed with a foul feces smelling substance extensively on the inside and outside of the toilet, smeared all over the surface of the sink, on the floor throughout the bathroom, and on 3 plastic bottles on the sink and floor. The floor was littered with blackish unidentified clumps, shredded toilet paper and a smashed styrofoam cup. On 9/27/21 at 3:50 p.m., a second observation of the resident's room and bathroom, no housekeeping services had been provided. On 9/28/21 at 9:43 a.m., a third observation of the room and bathroom. Additional unidentified dark balls of debris throughout the resident room, and the bathroom remained heavily soiled. b. Room 302 the tiled floor was heavily soiled with dust, debris, and was sticky to walk on. The bathroom was observed with a dark sticky substance on the floor around the toilet. The window blinds had 6 slats broken out leaving a hole in the blinds, and the remainder of the 6 slats hanging loose. c. Rooms 304, 306, and 307 tiled floors were heavily soiled with dirt and debris. d. Room 310 tiled floor heavily soiled with dirt and debris, also with an unidentified dried red sauce smeared in front of the wardrobe. e. Room 312 had an unidentified dark dried sticky substance tracked throughout the room and out into the hallway, and 2 aerosol cans of room freshener spray in the bathroom.		needed, the QAPI committee will write an Action Plan. Any Action Plan will be monitored by the Administrator weekly until resolved	

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	f. Room 314 tiled floor was heavily soiled with dirt and debris, and soiled vinyl gloves were on the floor near the doorway. The floor on the window side of the room had copious amounts of food and food debris under the resident's chair, on the floor, under the bed, and throughout the bedding. An unidentified red stain soiled a large area on the floor in front of the resident's bed and the floor around the bedside stand. Qualified Medication Aide (QMA) 6 indicated the red substance might be spilled juice. g. During a continuous observation of the 300 hallway from 10:15 a.m. to 11:00 a.m. there was no observation of a housekeeper on the hallway. On 9/27/21 at 11:03 a.m. during the tour of the 200 hallway, the following was observed: a. Debris and sticky floors observed throughout the length of the hallway to include food with some smashed into the floor, paper pieces, and clumps of dark substances. Shoes stuck to the floor when walking the entire length. a. Room 215 floor was littered with food debris, and 6 chunks of feces looking substance on the floor. b. Room 213 with a substantial amount of food debris under the bed nearest the door to include french fries and plastic cups. c. Room 214 the bed nearest the window had items under the bed to include a soda can, socks, and a soiled washcloth. Under the empty bed near the doorway was littered with plastic drinking cups, a plastic medication cup, and unidentified food pieces. d. Room 209 had a feces looking substance down the front of the toilet. e. Room 207 the tiled floors were sticky to walk on throughout the room, and the floor littered with debris to include food pieces, soiled vinyl gloves, and plastic spoons.			

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	f. Room 203 the tiled floor was littered with napkins, paper pieces, straw paper, food pieces, and an unidentified red substance on the bedding. g. During continuous observation of 200 hallway from 11:03 a.m. to 11:40 a.m., there was no observation of a housekeeper on the hallway. On 9/27/21 at 11:17 a.m. the handrail between room 214 and the storage closet was pulled away from the wall, screws exposed, and the railing hanging loose near room 214. The handrail between rooms 214 and 210 was missing from the wall. An end cap to the handrail was missing near room 207 and covered with white medical paper tape. The handrail between room 202 and the end of the hallway was loose and pulled away from the wall near room 202, the screws were visible when pulled out. On 9/27/21 at 3:38 p.m. during the tour of the 100 hallway, the following was observed: a. The access hallway at the top of the 100 hallway was littered with dried leaves and scraps of paper. b. Room 104 had soiled under pads and wadded up socks on the floor. c. Room 108 a long green strip from a plastic under pad lying on the floor near the end of the bed, and tape on the floor between the bed and doorway. An aerosol can of disinfectant spray was observed on the over the bed table among the resident's snacks and bottles of soda. On 9/27/21 at 3:45 p.m., there was no observation of a housekeeper in the facility during the survey process this date. The floors throughout the facility remained littered with debris. The tiled floors throughout the facility did not appear to have been swept or mopped in several days due to the amount of dirt and debris observed.			

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	On 9/28/21 at 9:42 a.m., a second observation of the environment throughout the facility to include hallways, resident rooms, dining rooms, chapel, resident bathrooms, and common areas. All heavily soiled with food, paper, and plastic debris. Dirt build-up along the cove base and on the floor indicate lack of floor care for a significant length of time. On 9/28/21 at 9:46 a.m., room 314 tiled floor was observed to have shoe prints, spills, scuff and stains, and food crumbs. On 9/29/21 at 9:47 a.m., room 312 was observed to have shoe prints, spills, and scuff marks throughout the room. On 9/28/21 at 9:49 a.m., the floor outside of nurses' station, and around a resident chair near the Social Service Designee (SSD) office, was observed to have skid stains and paper debris scattered on the floor. On 9/28/21 at 9:51 a.m., observation of the heavily soiled room and bathroom in room 301 with the Director of Nursing (DON). The DON indicated the facility kept hiring housekeeping staff, but they kept leaving. The maintenance man mopped the 100 hallway yesterday but did not mop in resident rooms or any common area. The DON indicated the 100 hallway should not be that bad as it was her hallway to monitor for cleanliness. Nursing staff attempted to assist with housekeeping by emptying resident trash cans. An Environmental Services Schedule, dated 9/5/21 - 9/27/21, indicated 4 housekeeping/laundry persons had quit or been terminated off the schedule, 1 staff member was on vacation, and			

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	there had been staff call offs. The schedule indicated the number of housekeeping/laundry personnel in the facility to cover both areas daily fluctuated from 1 to 3. On 9/27/21 at 10:22 a.m., QMA 6 indicated she normally worked the night shift and she never saw housekeeping. On 9/27/21 at 10:25 a.m. Certified Nursing Assistant (CNA) 5 indicated she had worked in the facility for a month and had seen 2 housekeepers that work only on the day shift. It was her opinion that the 2 housekeepers needed help, as the floors had not been swept in the facility for a while. The nursing staff would sweep and clean the desk with disinfectant wipes at times due to the mess. CNA 5 indicated room 301 had gnats as they kept a lot of food, it should have been cleaned every shift. On 9/27/21 at 10:32 a.m., CNA 7 indicated, about a week or two ago the facility had hired a new laundry lady and she had experience. On 9/27/21 at 3:34 p.m., CNA 11 indicated he normally worked on the 200 hallway. This was the season for gnats and the residents liked their snacks and it would attract the gnats. It was not his job to take care of housekeeping or gnats, but he did report issues to the appropriate department. On 9/27/21 at 11:44 a.m., the Housekeeping/Laundry Supervisor indicated her laundry person had quit so she was filling in doing laundry. There were currently 2 housekeepers on the schedule, and neither one was in the facility, leaving no housekeeper. She would have to try and help where needed.			

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	On 9/28/21 at 9:57 a.m., Housekeeper 12 was observed walking around the main nurses' station without a housekeeping cart or cleaning supplies. He indicated he had not worked over the past 3 days. Housekeeper 12 indicated there was a lack of housekeeping staff in the facility causing it to be dirty. The housekeeping staff consisted of the Housekeeping/Laundry Supervisor and 2 housekeepers. Most days the supervisor was doing laundry and there would be 1 housekeeper responsible for the mopping and cleaning of all areas of the facility. Occasionally there were 2 housekeepers on the floor, but they could not keep up with the cleaning of the facility. He indicated he was responsible for cleaning all the 100 and 300 hallways that date. On 9/28/21 at 10:05 a.m., Housekeeper 13 was observed coming from the laundry room. He indicated he had not worked over the past 3 days, but Housekeeper 12 should have been there as it was his weekend to work. There were only 2 housekeepers and the supervisor trying to cover cleaning of the facility and doing laundry. The facility had hired some staff and they went through orientation, then they just did not show up. It was his opinion they could not keep up and needed more help. He was responsible for laundry that date but would also help out sweeping the floors. On 9/28/21 at 10:38 a.m., the Administrator (ADM) indicated she was responsible for hiring of housekeeping staff, and she was aware the facility had not been being cleaned adequately. She had been hiring staff and either they did not show up or quit without notice. She had not been informed the laundry lady had not shown up all weekend, and when she contacted her the day before was			

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	told she had quit without notice. On 9/27/21 at 11:08 a.m., Licensed Practical Nurse (LPN) 8 indicated she thought there had been a housekeeper in room 207 earlier, she was the only one she had seen so far, and she did not remember her name. The maintenance man helped out with housekeeping sometimes as needed. On 9/28/21 at 1:52 p.m., the Housekeeping/Laundry Supervisor was observed providing housekeeping services on the 200 hallway. She had worked in the facility for the past 3 months but had not been put in the supervisory position until more recently. The ADM was responsible for hiring of housekeeping/laundry personnel and providing a working schedule for those departments. There were currently she and 2 housekeepers to cover the schedule. She was not sure how long it had been since the floors had been swept and mopped throughout the facility, or the resident rooms cleaned. Housekeeper 12 had been scheduled over the weekend with a laundry girl, but she quit without notice and did not come in. She was not sure if Housekeeper 12 had then covered laundry or provided housekeeping. It was her understanding there was a housekeeping check off list for staff to document when resident rooms, front offices, and common areas were cleaned, but she had not been provided with those forms as of that time. It was ultimately her responsibility to assure the facility housekeeping duties were completed and resident rooms cleaned, but with lack of staff they were just all working together and doing the best they could. On 9/28/21 at 2:15 p.m., the ADM indicated the maintenance man was responsible for making sure the handrails in the hallways were secured to the			

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	walls and repaired as needed. When staff noticed railing issues, they should have made out a work order for him and the handrails should have been repaired. If staff noticed the railing piece missing and put a piece of paper nursing tape over the end, they obviously noticed it needed repaired and should have made out a work order. On 9/28/21 at 3:06 p.m., the Infection Preventionist (IP) indicated residents were not allowed to have aerosol cans of air freshener or disinfectant sprays in their rooms. Hazardous materials were to be locked up. On 9/28/21 at 3:11 p.m., the Maintenance Supervisor indicated he had not been aware of the broken and missing handrails on the 200 hallway, and he had not received a work order. He indicated as the staffing was short, no one was going around and checking for environmental issues. On 9/28/21 at 11:30 a.m., the Administrator provided a Resident Room - Clean policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, to provide a clean, attractive and safe environment for residents, visitors and staff. The procedure included, general inspection of the resident room and picking up loose trash, removal of general waste from the resident's room, high and low dusting, cleaning and disinfecting the room furnishings, cleaning the phone, bedside commodes, toilet, handrails, nurse call and cord, and cleaning and restocking the bathroom. The resident's room and bathroom floors were to be cleaned with the dust mop then wet mopped. The toilet was cleaned and sanitize, and periodic cleaning of ceramic tile and grout in the bathroom.			

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	On 9/28/21 at 11:30 a.m., the Administrator provided a Public Lounges/Lobbies/Hallways-Clean policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, to provide clean, orderly, and attractive public areas for residents, visitors and staff that enhance the image of the facility. The policy indicated, clean and disinfect all handrails, doorknobs, window glass and frames, fire/smoke doors, and hardware. Remove waste by removing plastic trash liners, disposing of waste in the waste container, wiping the waste container, and relining the trash container, high and low dusting, and cleaning the floor. This Federal tag relates to Complaint IN00362059. 3.1-19(f)(3) 3.1-19(f)(5)			