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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155289	A. BUILDING 00 B. WING	05/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL OAKS HEALTH CARE CENTER	4725 S COLONIAL OAKS DR MARION, IN 46953

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 3, 4, 5, 6, and 7, 2021. Facility number: 000186 Provider number: 155289 AIM number: 100266300 Census Bed Type: SNF/NF: 98 Total: 98 Census Payor Type: Medicare: 33 Medicaid: 53 Other: 12 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review commmpleted on May 13, 2021.	F 0000	We at the facility are hereby respectfully requesting this agency consider paper compliance/desk review for compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is provided as evidence of the facilities desire to comply with regulations and continue to provide quality care. Please accept this Plan of Correction as our credible allegation of compliance.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to ensure narcotics were signed off as given after the medication was removed from the narcotic box for 2 of 3 narcotic administration observations. Findings include: 1. On 5/6/21 at 11:11 a.m., LPN 41 set up and administered Norco (narcotic pain reliever) 7.5 -325 (mg) milligram to a resident and she indicated her narcotic count binder was located at the nurses station, after she passed her meds, she recounted the medications in the narcotic drawer. At 11:48 a.m. LPN 41 retrieved the narcotic count binder from the nurses station. She signed off the Norco 7.5 - 325 mg that was administered at 11:11 a.m. and signed off narcotic medications that were administered at 8:00 a.m. that included, Pregabalin (nerve pain reliever) 50 mg, Vimpat	F 0761	1) No residents experienced adverse reactions related to this deficient practice. LPN 41 and RN 47 received one on one inservicing by the Director of Nursing. 2) All residents residing in the facility that receive narcotic medications have the potential to be affected by this deficient practice. LPN 41 and RN 47 received one on one inservicing by the Director of Nursing. 3) Staff that are responsible for administration of narcotic medication were re-inserviced regarding the facility policy and procedure for Controlled Substances. The facility policy and procedures for Controlled Substances was reviewed with no changes indicated.	06/01/2021

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	(anticonvulsant) 100 mg and a Fentanyl (narcotic pain reliever) 50 mcg/hr (microgram/hour) patch. 2. On 5/6/21 at 11:55 a.m. RN 47 set up and administered Norco 5 -325 mg to a resident. RN 47 indicated she signed off her narcotics in the narcotic count binder at the end of her medication pass. A 10/17 revised policy, titled "Controlled Substances," provided by the DON on 5/6/21 at 4:04 p.m., indicated the following: "Policy: It is the policy of this facility to store, administer, verify, and destroy controlled substances in accordance with Federal, State, and Local laws...General Considerations: ...5. When a controlled substance is not in the dispensing unit, a controlled substance count record will be maintained and the nurse/QMA (where applicable) will sign on the record when removing the medication for administration...." 3.1-25(e)3		4) The Director of Nursing and/or designee will complete random observations of the administration of controlled substances five times a week for four weeks, then three times a week for four weeks, then monthly thereafter. The audit will be documented on the Facility Controlled Substance Administration Observation Form (Attachment A). 5) Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved the Director of Nursing and/or designee will randomly complete the observation to ascertain continued compliance at least biannually The Director of Nursing report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
F 0880 SS=E 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.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of 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			

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	communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	A. Based on observation, interview, and record review, the facility failed to ensure masks were worn and handled in accordance with professional standards and hand hygiene was performed as indicated to mitigate the risk of transmission of COVID-19 during 4 of 4 random observations on the Chestnut hallway (green and yellow zones) and Redbud hallway (green zone). B. Based on observation, interview, and record review, the facility failed to ensure shared glucometers were disinfected according to facility policy for 1 of 1 observations of glucometer use on the Hickory hallway. C. Based on observation, interview, and record review, the facility failed to ensure a visitor donned PPE as indicated while in the room with a	F 0880	1) No residents were negatively affected by these practices. LPN 33, CNA 34, CNA 31, RN 7, Resident 288's visitors, CNA 54, LPN 53, Screener 51 received one on one inservicing by the Director of Nursing and/or Facility Infection Preventionist. 2) Residents who reside in the facility that are in contact with staff members and/or visitors have the potential to be affected by these practices. 3) Facility Staff were re-inserviced regarding: • The IDOH COVID-19 LTC Facility	06/01/2021

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	resident on transmission based precautions (TBP) for observation of COVID-19 during a 1 of 1 random observation of the Walnut hallway (Resident 288). Findings include: A. 1. During a random observation of the Chestnut hallway, on 5/3/21 at 11:33 a.m., LPN 33 donned a gown outside of a resident room. She then removed her procedure mask and placed it on top of the PPE cart. She donned an approved KN95 mask, picked up the doffed mask, and walked away to remove gloves from a different PPE cart. She had not performed hand hygiene. She discarded the mask, and then dropped the gloves when she dispensed hand sanitizer into her hands while holding the gloves. She then retrieved another pair of gloves and donned them before entering the room. She indicated, at the time of the interview, the doffed mask should not have been placed on the cart. A. 2. During a meal tray passing observation on the Chestnut hallway, on 5/3/21 at 11:34 a.m., CNA 34's procedure mask was pulled below her nose as she delivered meals to residents in their rooms. She then approached a room with a TBP sign on the door. She donned an approved KN95 mask, leaving her procedure mask pulled down to her chin underneath it. After delivering the meal and leaving the room, she doffed the KN95 mask by touching the front of the mask and placed it in a paper bag. She labeled the bag and placed it on the handrail. She did not perform hand hygiene until after she had placed the bag on the railing. During an interview, at the time of the observation, CNA 34 indicated she couldn't get her procedure mask off (from the mask securing		Infection Control Standard Operating Procedure • The cdc.gov "Your Guide to Masks" • The Facility Policy and Procedure for Glucose Meter Cleaning & Testing • Facility Policy for Transmission-Based Precautions (TBP's) • Long-term Care Facilities Guidelines in Response to COVID-19 Vaccination • The Facility Policy and Procedure for Handwashing • The Facility Policy and Procedure for Personal Protective Equipment (PPE) and the cdc.gov "Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19". The facility policy and procedure for Glucose Meter Cleaning & Testing, Transmission-Based Precautions (TBP's), Handwashing, and Personal Protective Equipment were reviewed with no changes indicated. Facility has ensured hand hygiene items, including soap and water and/or ABHR is available at all times. 4) The Director of Nursing, Facility Infection Preventionist, and/or designee will complete random Infection Prevention and Control Observations, Handwashing Skill	

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	device on the back of her head), so she just pulled it down. A. 3. During a random observation, on 5/3/21 at 3:00 p.m. on the Redbud hallway, CNA 31 was in the hallway with her mask below her nose and the nose band not bent. She had to repeatedly pull the mask up with her hand and did not perform hand hygiene afterwards. During an interview, at the time of the observation, she indicated her mask should be above her nose. A. 4. During a random observation, on 5/3/21 at 3:40 p.m., a used approved KN95 mask was laying on the medication cart keyboard. During an interview, at 3:43 p.m., LPN 33 was wearing a KN95 mask and there was now a used procedure mask on the keyboard. She indicated she had changed out of the KN95 and donned a procedure mask, then changed back to the KN95 mask. She held the procedure mask in her hands during the interview, rubbing her hands on it as she spoke. She indicated she should not have left the masks on the keyboard and would throw away the procedure mask since she had rubbed her hands on it. During an interview, on 5/3/21 at 3:44 p.m., the DON indicated the staff had been trained to wear masks with them covering both their noses and mouths. Review of the "IDOH COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, " updated 5/3/21, indicated the following: "...Direct care providers should wear a surgical mask for the duration of their shifts. Indirect care providers should wear a mask during their shifts. N95 (or approved KN95) masks should be worn in COVID units and with any		Competencies, Donning and Doffing Competencies and Blood Glucose Testing and Cleaning Competency Demonstrations daily on varying shifts for six weeks then three times a week for six weeks, then twice a month thereafter. The audits will be documented on the Facility Infection Prevention and Control Observation Audit form, the Handwashing/Handrub Competency form, the Donning and Doffing Competency form, and the Facility Blood Glucose Testing and Cleaning Competency evaluation form (Attachment B, C, D, E). 5) Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved the Director of Nursing and/or designee will randomly complete the observation to ascertain continued compliance at least biannually The Director of Nursing report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. The facility will ensure this requirement is met through application of the following	

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	resident who is symptomatic or awaiting testing in transmission-based precautions (red or yellow zone)...." Review of the "Your Guide to Masks," updated 4/6/21 and retrieved from cdc.gov, indicated the following: "Be sure to wash your hands or use hand sanitizer before putting on a mask. Do NOT touch the mask when wearing it. If you have to often touch/adjust your mask, it doesn't fit you properly, and you may need to find a different mask or make adjustments. Covers your nose and mouth and secure it under your chin. Fits snugly against the sides of your face...."B. During a random observation, on 5/3/21 at 12:07 p.m., RN 7 walked up to the medication cart with a blood glucose meter in her gloved hands, she wiped the blood glucose meter with an alcohol pad, then placed the meter on top of the medication cart, no barrier had been between the meter and the medication cart. During an interview immediately following the random observation, RN 7 indicated she used the one blood glucose meter for all residents on Hickory Hall and there was not a specific time the meter needed to remain moist for it to be disinfected. During an observation of a blood glucose being obtained, on 5/3/21 at 12:14 p.m., RN 7 placed the blood glucose meter on top of the resident's bed, and donned gloves, the resident was lying in the bed, she picked up the meter and obtained the blood sample, placed the meter back onto the resident's bed until the results were shown, picked the meter up off of the resident's bed, exited the room, walked down the hall back to the medication cart, placed the meter on top of the medication cart, doffed her gloves, performed hand hygiene, retrieved an alcohol pad from the medication cart, picked up the meter and wiped it with the alcohol		Directed Plan of Correction. No residents were negatively affected by this practice. All residents who reside in the facility that are in contact with staff members and/or visitors have the potential to be affected by these practices. Root cause analysis Findings: During the facility visit for Recertification and State Licensure Survey, the surveyors noted the facility failed to ensure masks were worn and handled in accordance with professional standards, that hand hygiene was performed as indicated, shared glucometer devices were disinfected according to facility policy, appropriate donning of PPE was completed by a visitor as indicated. What: • Residents, visitors, and staff should wear masks as indicated per guidance including wearing mask correctly and consistently. • Staff should handle masks according to professional standards. • Staff should complete appropriate hand hygiene including the use of ABHR when indicated to prevent the spread of infection. • Glucometer devices should be disinfected utilizing the appropriate germicidal wipes according to facility policy and policy to prevent cross contamination and minimize	

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	pad, and placed the meter in the top drawer of the medication cart. No barrier had been used between the meter and the top of the medication cart or between the meter and where she had placed it in the top drawer of the medication cart. Review of a current facility policy, titled "Glucose Meter Cleaning & Testing," with a revised date of 9/19 and provided by the Nurse Consultant on 5/7/21 at 10:22 a.m., indicated "...Cleaning meter after use... Steps: 1. Perform hand hygiene. 2. Place clean paper towel, plastic cup or clean barrier on hard surface. 3. Put on gloves. 4. Obtain (2) single use germicidal wipes. 5. Wipe entire external surface of the blood glucose meter with one germicidal wipe and ensure meter stays wet for 2 minute time period...6. Place clean meter on clean paper towel, in plastic cup or on a clean barrier to store until next use...."C. On 5/4/21 at 10:52 a.m., Resident 288's room was observed with a contact/droplet isolation sign on the door. During a random visitor interview, on 5/4/21 at 3:18 p.m., a visitor indicated the facility asked screening questions, obtained her temperature, and then directed her and another visitor to the resident's room. She indicated they did not receive any special guidelines to follow while they was in the facility visiting. During an observation, on 5/5/21 at 1:35 p.m., Resident 288 was sitting in her recliner without a face covering. A visitor was sitting next to her, in a chair, within 3 feet. Resident 288's room contained contact/droplet isolation signs on the door and the door was entirely open. The compassionate care visitor had a surgical mask on for personal protective equipment. The visitor did not wear an N95 (respirator) or KN95 (respirator) mask, face shield, gown, or gloves. During the		risk of transmitting blood-borne pathogens between residents that require blood glucose monitoring. • Donning and doffing of PPE should be completed as indicated to prevent transmission of infectious illness or pathogens. Why: • Staff handled masks inaccurately related to various reasons including nervousness, ill-fit, need for additional training, etc. • Compassionate Caregiver stated he had forgot instructions related to utilization of PPE including use of masks for resident. Staff failed to assist Compassionate Caregiver to room and ensure appropriate PPE was donned. Staff was unaware they should re-direct compassionate caregivers/visitors/residents regarding PPE usage including masks. Staff monitoring visitation did not enforce adherence to guidance. • Competency training for specific nurse was not completed related to Blood Glucose device cleaning. Immediate Corrective Action: • LPN 33, CNA 34, CNA 31, RN 7, Resident 288's visitors, CNA 54, LPN 53, Screener 51 received one on one inservicing by the Director of Nursing and/or Facility Infection Preventionist.	

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	visitor observation, Certified Nurse's Aide (CNA) 54 stopped at the resident's door, facing the resident and her visitor, and asked the resident if she needed to use the restroom. She did not redirect the resident to wear a mask for visitation nor did she educate the visitor to don additional personal protective equipment for the isolation room. CNA 54 continued on to address a call light in another room. During an interview, on 5/5/21 at 1:41 p.m., CNA 54 indicated Resident 288's spouse was visiting with her. She indicated residents in isolation were permitted to have visitors. She did not provide any redirection for the resident nor the visitor at this time and proceeded into another resident's room. During an interview, on 5/5/21 at 1:43 p.m., Resident 288's spouse indicated he had not received any information regarding specific PPE he had to wear during visits. He indicated his strap broke on the other mask they gave him previously and he asked an unknown staff member if he could wear the surgical mask and they told him it should be okay since his glasses sat on top of the surgical mask. During an interview, on 5/5/21 at 1:49 p.m., Licensed Practical Nurse (LPN) 53 indicated compassionate care visitors were screened by temperature monitoring and a questionnaire, but she was unsure about the details of education they received and referenced the Administrator. During an interview, on 5/5/21 at 1:54 p.m., the Administrator indicated compassionate care visitors were provided personal protective equipment (PPE) education prior to beginning compassionate care visits but were not educated		Corrective Measures: • Reeducation and inservices with staff including: o IDOH COVID-19 LTC Facility Infection Control Standard Operating Procedure o Your Guide to Masks (cdc.gov) o Facility Policy and Procedure for Glucose Meter Cleaning & Testing o Facility Policy and Procedure for Transmission-Based Precautions (TBP's) o Long-term Care Facilities Guidelines in Response to COVID-19 Vaccination o Facility Policy and Procedure for Handwashing o Facility Policy and Procedure for Personal Protective Equipment (PPE) o Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19. Summary: • Root cause analysis determined the need for Facility IP nurse, DON, and HFA to ensure a persistent increase in frequency of reeducation and auditing to assure the appropriate implementation of Infection Control and Prevention guidance for staff, residents, and visitors as indicated. The Director of Nursing, Facility Infection Preventionist, and/or designee will complete random Infection Prevention and Control	

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	each compassionate care visit. He indicated compassionate care visitors are required to wear a face shield, KN95 mask, and a gown in an isolation room. He indicated all staff monitor and are required to immediately notify the Administrator if a visitor is not complying with infection control procedures for intervention. During an observation and interview after the discussion of visitor requirements, on 5/5/21 at 1:57 p.m., LPN 53 indicated a visitor of Resident 288 was not wearing appropriate PPE for isolation. Review of a Visitor Screening Tool dated 5/5/21, and provided by Receptionist 52 on 5/5/21 at 2:26 p.m., indicated Resident 288's spouse arrived for his visit with the Resident 288 on 5/5/21 at 12:50 p.m. The screening tool indicated the visitor was not fully vaccinated. Resident 288's clinical record review was completed on 5/6/21 at 3:15 p.m. Resident 288 admitted to the facility on 4/21/21. Diagnoses included, but were not limited to, unspecified dementia without behavioral disturbances and other cerebral infarction. Orders included, but were not limited to a COVID evaluation daily dated 4/21/21. The clinical record indicated the resident refused the COVID-19 vaccinations on 4/21/21 and indicated the resident had not received the COVID-19 Vaccination nor been diagnosed with COVID-19 in the past 90 days. A 4/22/21 care plan indicated Resident 288 was in droplet isolation for observation of signs and symptoms of COVID-19 infection due to a recent admission to the facility. Interventions included, but were not limited to the following: the resident		Observations, Handwashing Skill Competencies, Donning and Doffing Competencies and Blood Glucose Testing and Cleaning Competency Demonstrations daily for six weeks then three times a week for six weeks, then twice a month thereafter. The audits will be documented on the Facility Infection Prevention and Control Observation Audit form, the Handwashing/Handrub Competency form, the Donning and Doffing Competency form, and the Facility Blood Glucose Testing and Cleaning Competency evaluation form (Attachment B, C, D, E). Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved the Director of Nursing and/or designee will randomly complete the observation to ascertain continued compliance at least biannually The Director of Nursing report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. Survey findings, root cause analysis reviewed with corporate IP, Medical Director, Administrator, Facility IP nurse, and Facility Director of Nursing.	

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	155289	A. BUILDING 00 B. WING	05/07/2021

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	was in 14 days of transmission based precautions; wear personal protective equipment as designated by the facility policy; follow the building re-opening/visitation plan; educate staff, resident, family and visitors of COVID-19 signs, symptoms and precautions; and follow facility protocol for COVID-19 screening and precautions. A 5/6/21 nurse's note indicated the resident completed her fourteen days of transmission based precautions. During a random visitor screening observation, on 5/7/21 at 9:05 a.m., Screener 51 was observed asking a visitor if she knew where she was going after the screening questionnaire was completed. The visitor was not escorted to the resident's room. During an interview with Screener 51, on 5/7/21 at 9:13 a.m., she indicated visitors were permitted to go to the resident's room by themselves, after they screened, if the resident was in a private room. She indicated this process was the same regardless of the visitor's COVID-19 vaccination status. During an interview, on 5/7/21 at 1:39 p.m., LPN 55 indicated neither Resident 288 nor her spouse were vaccinated for COVID-19. During an interview, on 5/7/21 at 1:56 p.m., the Administrator indicated he met with Resident 288's spouse on 4/20/21 to provide compassionate care visitor education. A copy of the compassionate care packet, provided by the Administrator on 5/7/21 at 1:56 p.m., and indicated each visitor must wear a mask while in the facility. It lacked mask detail for residents in Transmission Based Precautions and did not contain a date or		The plan of action was agreed upon.	

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acknowledgement signature. He indicated the facility could not ensure a visitor had donned proper PPE when they entered the resident's room without an escort, but they had the expectation that visitors followed the education they were provided in the original meeting before they started the compassionate care visits. He indicated the facility followed the Indiana State Department of Health guidelines.

Review of a current facility policy, titled "TRANSMISSION-BASED PRECAUTIONS (TBP's)," dated 10/25/20 and provided by the Nurse Consultant on 5/7/21 at 10:22 a.m., indicated "...2. Contact Precautions... Gloves and Handwashing: *...wear gloves (clean, non-sterile) when entering the room...Gown *Wear a disposable gown upon entering the Contact Precautions room or cubicle...3. Droplet Precautions...Masks/Eyewear *...mask and eyewear is universal when providing direct resident care...."

A current Indiana State Department of Health document, titled "Long-term Care Facilities Guidelines in Response to COVID- 19 Vaccination," provided by the Administrator on 5/7/21 at 1:56 p.m., indicated the following: "...New Admissions or Readmissions: CDC recommends managing the unknown COVID-19 status for all new admission or readmissions to the facility....Unknown COVID-19 Status: ...All recommended PPE should be worn during care of newly admitted or readmitted resident under observation for unknown COVID status; ...CORE PRINCIPLES OF INFECTION PREVENTION...As long-term care facilities move to a reopened phase in resident care, it is expected that COVID-19 infection prevention and control core principles be always adhered to and remain in place as long

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	as the virus is present in epidemic levels. Facilities should be mindful of the core principles of infection prevention for COVID-19 when implementing visitation or conducting any activity for the residents:...VISITATION...Visitors: Visitors should be able to adhere to the core principles. Visitors that do not adhere to the core principles should be asked to leave the facility.... If resident or visitor is not fully vaccinated, ideally both should wear masks and physically distance..." 3.1-18(l)			
F 0921 SS=D 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 ensure heavy wooden doors were not held open in a potentially hazardous manner for two random observations on the Redbud hallway. Findings include: 1. During a random observation, on 5/3/21 at 2:55 p.m., the shower room door on the Redbud hallway was held open with a shower curtain (hanging from the interior ceiling) wrapped around the handle. The door had a keypad lock on the front of it. During an interview on 5/3/21 at 3:00 p.m., CNA 31 indicated the door was not to be held open with the curtain. Residents 67 and 11 were sitting in their doorways at the time of the observation; Resident 67 was propelling himself in and out of his room.	F 0921	="" p="">1) Resident 67 and 11 experienced no adverse reactions related to this deficient practice. ="" p="">2) All residents residing in the facility have the potential to be affected by this deficient practice. All doors are currently appropriately secured. ="" p="">3) Facility staff were re-inserviced on Securing of Doors. ="" p="">4) The Director of Nursing and/or designee will complete random observations of doors that are designated to be secured at all times five times a week for four weeks, then three times a week for four weeks, then monthly thereafter. The audit will be documented on the Facility	06/01/2021

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	2. During a random observation, on 5/4/21 at 9:55 a.m., the shower room door on the Redbud hallway was held open with the shower curtain wrapped around the handle. During an interview on 5/3/21 at 9:57 a.m., CNA 32 indicated the door should be kept closed. 3.1-19(f)(5)		Secured Door Observation form (Attachment F). ="" p="">5) Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. After consecutive compliance is achieved the Director of Nursing and/or designee will randomly complete the observation to ascertain continued compliance at least biannually The Director of Nursing report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. ="" p=""> ="" p=""> ="" span="">	