| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 06/24/2021 |

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| WHITLOCK PLACE | 1719 S ELM ST<br>CRAWFORDSVILLE, IN 47933 |

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00355762.<br><br>Complaint IN00355762 - Substantiated. State deficiencies related to the allegations are cited at R52.<br><br>Survey dates: June 23 and 24, 2021<br><br>Facility number: 004419<br><br>Residential Census: 53<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on July 1, 2021. | R 0000 | *Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.* | |
| R 0052<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(v)(1-6)<br>Residents' Rights - Offense<br>(v) Residents have the right to be free from:<br>(1) sexual abuse;<br>(2) physical abuse;<br>(3) mental abuse;<br>(4) corporal punishment;<br>(5) neglect; and<br>(6) involuntary seclusion.<br>Based on record review and interview, the facility failed to ensure a resident with exit seeking behavior did not elope from the facility for 1 of 3 residents reviewed for elopement risk which resulted in the resident being found by police 3 blocks away from the facility (Resident | R 0052 | **R 052 Residents' Rights - Offense**<br><br>**1. What corrective action(s) will be accomplished for those residents found to have been** | 07/24/2021 |

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

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| | B).<br><br>Findings include:<br><br>Resident B's record was reviewed on 6/24/21 at 9:45 a.m. A resident information sheet indicated the resident was admitted to the facility on 12/14/20.<br><br>A mini mental exam (a test of cognitive function), dated 4/13/21, indicated the resident had a mild cognitive impairment.<br><br>A resident service note, dated 6/11/21 at 5:00 p.m., indicated the resident attempted to go out the front door, and the alarm sounded.<br><br>A resident service note, dated 6/11/21 at 7:00 p.m., indicated the resident made two more attempts to get out of the building and was redirected.<br><br>A resident service note, dated 6/11/21 at 8:40 p.m., indicated the staff heard the front door alarm sounding and searched the building. 911 was called, and a bystander reported seeing her. The police returned the resident to the building. The resident was three blocks away when she was found.<br><br>A resident service note, dated 6/11/21 at 9:45 p.m., indicated the resident left the facility with her family, and would stay with them until placement was decided.<br><br>A resident service note, dated 6/12/21, indicated the resident and her family returned to the facility, packed her belongings, and the resident was transferred to another facility. | | **affected by the deficient practice?**<br>On 6/12/21, Resident B was relocated to a memory care unit and no longer resides in the community.<br><br>**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>On 07/15/2021, the licensed nursing staff updated mini mental exam's and elopement risk assessments of current residents who have diagnosis of dementia or cognitive impairment (Attachment 1). Care Service Manager updated the identified residents' plans of care with interventions designed to decrease the risk for elopement.<br>**3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?**<br>On 7/15/21, the Care Services Manager (CSM) was re-educated by the Regional Director of Care Services (RDCS) regarding the elopement policy and response to residents exhibiting exit seeking behaviors (Attachment 2). Elopement drills will be performed weekly for 4 weeks on varied shifts starting 07/19/21, and then monthly thereafter. Current staff | |

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| | During an interview, on 6/23/21 at 3:18 p.m., the Care Service Manager (CSM) indicated Resident B eloped from the facility on 6/11/21 at about 8:40 p.m. The staff heard the door alarm sounding, initiated a head count, realized the resident was not at the facility, and called 911. A bystander, unrelated to the facility, also reported to the police they saw the resident. The police located the resident and returned her to the facility, around 9:00 p.m. The resident had impaired safety awareness and was unable to safely leave the facility by herself.<br><br>During an interview, on 6/24/21 at 9:45 a.m., the CSM indicated the resident was discharged to a secured memory care facility.<br><br>On 6/23/21 at 3:07 p.m., the CSM provided a document titled, "ELOPEMENT OR MISSING RESIDENT," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: It is the policy...to provide a systemic effort of all community staff to search when a resident is reported missing and that person is cognitively impaired and leaves the community without staff knowledge and/or supervision, lacks safety awareness and is unable to distinguish/identify his or her safety needs and/or has impaired appropriate decision making ability. Process: First Response Plan (IMMEDIATE ACTION): A resident is considered missing when he or she leaves the community undetected and without notice to the community by writing in the Sign-out Log. Ensure resident did not leave with family or to an appointment and forgot to sign out. If this person is unable to navigate his or her way back, lacks safety awareness and is unable to distinguish/identify his or her safety needs, he or she is considered missing. If the resident has not | | are being re-educated on 07/16/21 by the Executive Director (ED) on the elopement policy and response to residents exhibiting exit seeking behaviors.<br><br>**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The CSM is responsible for sustained compliance. The ED or designee will audit 5 resident care plans weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month, to ensure the plan of care reflects appropriate interventions to decrease the risk for elopement. Audit results will be reviewed monthly at QI meetings to ensure compliance. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.<br>**5. By what date the systemic changes will be completed**<br>Completion date: 7/24/2021 | |

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| | been located in 30 minutes, then the ED or person in charge is called if the ED or person in charge is not in the community. The ED or person in charge the calls the police and provides name and description of resident...."<br><br>This State Residential Finding relates to Complaint IN00355762. | | | |
| R 0117<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(b)<br>Personnel - Deficiency<br>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.<br>Based on record review and interview, the facility failed to ensure a staff member with a first aid certification was at the facility for 6 of | R 0117 | **R 117 Personnel – Deficiency**<br><br>**1. What corrective action(s) will** | 07/24/2021 |

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| | 21 shifts reviewed.<br><br>Findings include:<br><br>On 6/24/21 at 2:10 p.m., the Executive Director (ED) provided the Residential Care Employee Records Form. The form indicated Resident Care Partner (RCP) 15 was the staff member designated as being first aid certified first shift on 6/17/21, 6/18/21, 6/19/21, and 6/20/21. RCP 13 was the staff member designated as being first aid certified on third shift on 6/18/21 and 6/22/21.<br><br>The current Licensure and Certification binder lacked documentation RCP 15 and RCP 13 were certified in first aid.<br><br>During an interview on 6/24/21 at 2:10 p.m., the ED indicated he reviewed the schedule for the week of, 6/16/21 to 6/23/21, and identified six shifts lacked a staff member certified in first aid. They thought the basic life support (BLS) certification covered first aid, so the staff members had not completed the first aid training. There should have been someone with a first aid certification in the facility at all times.<br><br>On 6/24/21 at 2:18 p.m., the ED provided a document titled, "FIRST AID," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: To provide guidelines for staff for basic first aid practices, which in turn will help minimize potential further injury and provide stabilization until emergency medical services are provided. In addition, staff members will be required to be first aid certified in states which require employees to obtain and maintain certification based on the state regulatory requirements...." | | **be accomplished for those residents found to have been affected by the deficient practice?**<br>On 7/15/2021, the ED reviewed and updated staffing schedule to ensure minimum of one employee with current first aid certification was present on each shift.<br><br>**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>An audit of employee first aid certification was completed on 7/15/2021 by the ED (Attachment 3). Employees without current first aid certification will obtain certification by 7/24/2021.<br><br>**3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?**<br>The ED was re-educated by RDCS on 07/15/2021 (Attachment 4) regarding the first aid regulation requirement.<br><br>**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The ED is responsible for sustained compliance. The CSM | |

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| | | | or designee will audit the staffing schedule weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure a first aid certified employee is on site at all times. The audits will be discussed at monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.<br><br>**5. By what date the systemic changes will be completed**<br>Completion date: 7/24/2021 | |
| R 0273<br><br>Bldg. 00 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.<br><br>Based on observation, interview, and record review, the facility failed to ensure the stove hood filter vent was cleaned from dust debris and grease for 1 of 1 kitchen observation and failed to ensure food was stored under sanitary conditions for 1 of 1 kitchen observations. The facility failed to ensure beverages were prepared and served under sanitary conditions from the dining room for 1 of 1 dining observation. This had the potential to effect 53 of 53 residents who received beverages that were served in the dining room.<br><br>Findings include: | R 0273 | **R 273 Food and Nutritional Services – Deficiency**<br><br>**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>The stove hood filter vent was cleaned on 06/30/21 by the Executive Director. The bananas, canned tomatoes, and pecans were disposed of on 07/01/21. Dietary Aide 12 was reeducated 07/08/21 regarding safe food | 07/24/2021 |

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| | 1. During an initial kitchen tour with the Assistant Chef (AC), on 6/23/21 at 10:05 a.m., the stove hood filter vent was observed to have dust debris and grease. At this time, the AC indicated the hood filter had dust debris and grease. The filter vent was scheduled to be cleaned every three weeks and should be cleaned more frequently.<br><br>On 6/23/21 at 10:40 a.m., the AC provided a cleaning schedule document dated May 2021. The document indicated on Wednesday pull hood filters, spray with degreaser, and run through the dishwasher for six minutes each and lacked documentation this had been completed from 5/1/21 through 5/31/21.<br><br>On 6/23/21 at 10:40 a.m., the AC provided a cleaning schedule document dated June 2021. The document indicated on Wednesday pull hood filters, spray with degreaser, and run through the dishwasher for six minutes each and lacked documentation this had been completed from 6/1/21 through 6/23/21.<br><br>On 6/24/21 at 9:15 a.m., the ED provided a document, dated 9/1/16, and titled, "Kitchen Sanitation, Equipment Maintenance and Safety," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Utensils, equipment, preparation surfaces and the kitchen area must be kept clean at all times and must be maintained to be easily cleaned at any time. Process: ...Schedules for routine and deep cleaning should be maintained and followed...."<br><br>2. During an initial kitchen tour with the Assistant Chef (AC), on 6/23/21 at 10:05 a.m., | | handling standards (Attachment 5).<br><br>**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>An audit of kitchen was done on 07/15/21 by the ED to ensure equipment is sanitized according to policy, food is labeled and stored appropriately, and safe food handling standards are being followed. No issues identified (Attachment 6).<br><br>**3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?**<br>Dietary staff were re-educated on 07/16/21 by the ED regarding the stove hood sanitation policy, food storage, and safe food handling standards.<br><br>**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The Chef is responsible for sustained compliance. The Executive Director or designee will conduct observational audits of the kitchen 3 times per week for 4 weeks, then 2 times per week for | |

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| | There were bananas and canned diced tomatoes observed on the floor in the dry storage room and a bag of pecans in a zip lock bag unsealed. The bag lacked an opened date and expiration date. She also indicated food items should be stored on shelves in the dry storage room, not on the floor as observed, and the pecans should have been sealed and dated with an open and expiration date.<br><br>On 6/23/21 at 2:49 p.m., the ED provided a document, undated, and titled, "Dining, Nutrition and Hospitality Services Resource Guide," and indicated it was the policy currently being used by the facility. The policy indicated, "...Food should be stored properly at all times...."<br><br>On 6/23/21 at 2:00 p.m., the Executive Director (ED) provided a document, undated, and titled, "Food Dating Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "Dating Basics. 1. All food and beverages must be dated with received date...3. All opened food and beverages must have an opened date and expiration date...."<br><br>3. During a dining observation in the dining room, on 6/23/21 at 11:02 a.m. to 11:06 a.m., Dietary Aide (DA) 12 was observed to open the kitchen door with gloved hands. She then proceeded to prepare and serve drinks with the same gloves on. At the time she served drinks to residents she was observed to touch the rim of the glasses.<br><br>During a dining observation in the dining room, on 6/23/21 at 11:09 a.m., DA 12 was observed to touch a resident's used glass with gloved hands and refilled the resident's glass with water. She was not observed to change her gloves or | | 4 weeks, then weekly for 4 weeks to ensure safe food handling and kitchen sanitation practices and procedures are maintained. Results of audits will be discussed in the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.<br><br>**5. By what date the systemic changes will be completed**<br>Completion date: 7/24/2021 | |

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| | perform hand hygiene and proceeded to prepare five other drinks and served to residents in the dining room. She then prepared a drink in a Styrofoam cup and with her gloved hands opened a straw and placed it into the cup.<br><br>During an interview, on 6/23/21 at 11:12 a.m., DA 12 indicated she wore gloves during dining service and would change them as needed.<br><br>On 6/24/21 at 10:28 a.m., the ED provided a document, dated 9/1/16, and titled, "Handwashing," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Handwashing is the single most effective means to prevent the spread of infection...Hands should be washed before: ...preparing, serving, or eating food...." | | | |
| R 0356<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(i)(1-8)<br>Clinical Records - Noncompliance<br>(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:<br>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.<br>(2) The resident ' s hospital preference.<br>(3) The name and phone number of any legally authorized representative.<br>(4) The name and phone number of the resident ' s physician of record.<br>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.<br>(6) Information on any known allergies.<br>(7) A photograph (for identification of the resident). | | | |

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| | (8) Copy of advance directives, if available.<br>Based on interview and record review, the facility failed to ensure an Advance Directive for Do Not Resuscitate (DNR) was signed by a physician in a timely manner for 1 of 5 residents reviewed for Advance Directives (Resident E).<br><br>Findings include:<br><br>On 6/23/21 at 11:04 a.m., Resident E was interviewed. She indicated, she had lived at the facility since the first week of March 2020. She could not remember the exact date she moved in, but remembered it was right before COVID (COVID-19, Coronavirus) had really hit [state name]. She stayed in her apartment for the better part of the last year, and had not left the facility until more recently, because of the high rates of COVID in the area.<br><br>On 6/23/21 at 2:25 p.m. a comprehensive medical record review was completed for Resident E. The record indicated, Resident E was admitted to the facility on 3/5/20.<br><br>A document titled, "[state name] Out of Hospital Do Not Resuscitate Declaration and Order" was completed on 3/5/20. The document was signed by the resident and Care Service Manager (CSM) on 3/5/2020. The physician did not sign and certify the order until 4/7/2020.<br><br>During an interview with the Executive Director (ED) on 6/24/21 at 10:27 a.m., he indicated, when a resident moved into the facility, they should have a code status (a physician order that indicated whether or not a resident would receive CPR, (cardiopulmonary resuscitation, life-saving measures), signed by the physician; along with TB (tuberculosis) screening and a chest x-ray. | R 0356 | **R 356 Clinical Records – Noncompliance**<br><br>**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>The Do Not Resuscitate (DNR) order for Resident E was signed by the physician on 4/7/2020.<br><br>**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>An audit of medical records was completed on 07/15/21 by the CSM to ensure advance directives are signed by the resident's physician in a timely manner (Attachment 7). No concerns identified.<br><br>**3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?**<br>The CSM was re-educated by the RDCS on 7/15/2021 regarding obtaining the physician's signature timely once a resident has selected an advanced directive (Attachment 8).<br><br>**4. How the corrective action(s)** | 07/24/2021 |

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| WHITLOCK PLACE | 1719 S ELM ST<br>CRAWFORDSVILLE, IN 47933 |

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| | The ED indicated this would all be required before the resident moved into the building. If there was no documented code status, or the code status order was not signed by a physician, facility staff would perform CPR on the resident in the case of a medical emergency.<br><br>On 6/24/21 at 10:41 a.m., the CSM with interviewed. She indicated, a resident's code status was kept in their medical record. The CSM indicated, she was the nurse who signed the DNR with the resident on 3/5/20. The Physician did not sign the form until 4/7/20. It was not facility practice to have a DNR unsigned for the thirty-three days the resident lived at the facility, before a physician signed the DNR order. She indicated, if Resident E would have had a medical emergency during that time, facility staff would have performed CPR, as the DNR could not be honored without a physician's signature.<br><br>On 6/24/21 at 9:15 a.m., the CSM provided a policy titled, "Advance Medical Directives", dated 9/1/2016. The CSM indicated, this was the current policy in use by the facility at that time. The policy indicated, "Each resident's Advance Directive will be honored and maintained in the resident's record." | | **will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The ED is responsible for sustained compliance. The CSM or designee will audit the resident advanced directive records weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure advance directives have been signed by a physician in a timely manner. Results of the audit will be discussed in the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.<br><br>**5. By what date the systemic changes will be completed**<br>Completion date: 7/24/2021 | |
| R 0407<br><br>Bldg. 00 | 410 IAC 16.2-5-12(b)(1-4)<br>Infection Control - Noncompliance<br>(b) The facility must establish an infection control program that includes the following:<br>(1) A system that enables the facility to analyze patterns of known infectious symptoms.<br>(2) Provides orientation and in-service education on infection prevention and control, including universal precautions.<br>(3) Offering health information to residents, | | | |

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| | including, but not limited to, infection transmission and immunizations.<br>(4) Reporting communicable disease to public health authorities.<br>Based on observation, interview, and record review, the facility failed to follow Centers for Disease Control (CDC) guidance during a pandemic and ensure infection control practices for COVID-19 were implemented for transmission-based precautions and daily monitoring of symptoms for 3 of 3 residents reviewed for infection control (Residents D, E, and C).<br><br>Findings include:<br><br>1. During a dining observation, on 6/23/21 at 11:12 a.m., Resident D was observed coughing with no mask covering the resident's face.<br><br>Resident D's record was reviewed on 6/23/21 at 3:20 p.m. A resident service note, dated 6/16/21 and untimed, indicated the resident had complaints of sore throat and cough. No fever was noted, and congestion was clear. The physician was notified for advisement.<br><br>A fax document, dated 6/16/21, indicated the physician was faxed at 4:17 p.m. Comments included, but were not limited to, resident had complaint of very sore throat, cough, and congestion. No fever was noted, and congestion was clear. A response from physician indicated Keflex (antibiotic) 500 milligrams (mg) give three times daily for 10 days and prednisone (steroid) 5 mg give four tablets for four days, two tablets for three days, and one tablet for three days.<br><br>A Medication Administration Record, dated June | R 0407 | **R 407 Infection Control – Noncompliance**<br><br>**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident C, D and E, were monitored for signs and symptoms of infection on 07/01/21 by the licensed nursing staff, with no concerns noted.<br>**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>An audit of resident temperature logs was completed on 07/15/21 by the CSM and findings reviewed with the ED. Revised screening log was implemented on 07/01/21 (Attachment 9), which includes monitoring residents for signs and symptoms of infection and temperature results.<br><br>**3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?**<br>The CSM was re-educated on 7/15/2021 by the RDCS regarding | 07/24/2021 |

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| | 2021, lacked documentation of a physician's order for the antibiotic and steroid.<br><br>A resident service note, dated 6/17/21 and untimed, indicated the resident received new physician orders for Keflex and prednisone and the daughter picked up medications and delivered to resident.<br><br>A review of the resident's clinical record, dated June 2021, lacked documentation the resident had been placed in transmission-based precautions (tbp).<br><br>During an interview, on 6/23/21 at 2:04 p.m., the Director of Nursing (DON) indicated it was not currently the facility policy to isolate a resident or rapid test a resident for COVID-19 if they had symptoms. She believed the resident may have been isolated for one to three days but she was unable to find any documentation that supported that. The facility should have followed CDC guidance and the tool kit provided by the state.<br><br>On 6/24/21 at 10:28 a.m., the Executive Director (ED) provided a document, undated, and titled, "Isolation Best Practices for Assisted Living Communities," and indicated it was the policy currently being used by the facility. The policy indicated, "Why Isolate Residents? The CDC says the best way to prevent illness from COVID-19 is to avoid being exposed to this virus. In your community, we require resident isolation when: ...there is a suspected or confirmed case of COVID-19 (resident or employee). When a resident is isolated, he or she should remain in his or her room 24 hours a day, including during mealtimes, unless specified by the resident's service plan...."2. On 6/23/21 at 2:25 p.m. Resident E's medical record was | | the resident screening process, placing symptomatic residents in transmission-based precautions, and documentation of symptoms and precautions in the service notes (Attachment 10). Current staff are being re-educated starting on 07/16/21 by the CSM regarding the resident screening process, placing symptomatic residents in transmission based precautions, and documentation of symptoms and precautions in the service notes.<br><br>**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The CSM is responsible for sustained compliance. The ED or designee will audit the resident screening log 5 days per week x 4 weeks, then 3 days per week x 4 weeks, then weekly x 4 weeks, to ensure that residents are being properly screened, symptomatic residents are placed in transmission based precautions, and documented in the service notes. Audits will be reviewed monthly at QI meetings to ensure compliance. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.<br>**5. By what date the systemic changes will be completed** | |

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| | comprehensively reviewed. The record indicated Resident E was admitted to the facility on 3/5/20. The record indicated the resident's temperature was checked at least daily, but lacked documentation any COVID-19 symptoms were monitored from the date of her admission to 6/23/21. 3. Resident C's record was reviewed on 6/23/21 at 1:59 p.m. A temperature log, dated June 2021, indicated the resident's temperature was checked daily, but lacked documentation any COVID-19 symptoms were monitored.<br><br>During an interview, on 6/23/21 at 12:20 p.m., the Care Service Manager (CSM) indicated residents' temperatures were checked daily, but they did not assess for any other COVID-19 symptoms. If a resident had an increased temperature, they would have asked them about any other symptoms at that time.<br><br>The Indiana Department of Health Long Term Care Toolkit, updated 6/4/21, indicated, "...Assess residents for symptoms of COVID-19 infection upon admission to the facility, and daily during this pandemic and implement appropriate infection prevention practices for incoming symptomatic residents. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea...Anyone with symptoms of COVID-19, regardless of vaccination status, should receive a viral test (i.e., PCR or antigen test) immediately. This includes...residents...residents should be placed in transmission-based precautions...." | | Completion date: 7/24/2021 | |

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| R 0410<br><br>Bldg. 00 | 410 IAC 16.2-5-12(e)(f)(g)<br>Infection Control - Noncompliance<br>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.<br>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br>Based on interview and record review, the facility failed to ensure a resident was screened for tuberculosis (TB) and had a chest x-ray prior to admission for 1 of 5 residents reviewed for TB and chest x-ray prior to admission (Resident E).<br><br>Findings include:<br><br>On 6/23/21 at 11:04 a.m., Resident E was interviewed. She indicated, she had lived at the facility since the first week of March 2020. She could not remember the exact date she moved in, but remembered it was right before COVID (COVID-19, Coronavirus) had really "hit" the state. She stayed in her apartment for the better | R 0410 | **R 410 Infection Control – Noncompliance**<br><br>**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident E received a chest x-ray on 3/20/2020, a first step tuberculin skin test on 4/8/2020, and a second step on 4/23/2020.<br>**2. How the facility will identify other residents having the potential to be affected by the same deficient practice and** | 07/24/2021 |

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| | part of the last year, and had not left the facility until more recently because of the high rates of COVID in the area.<br><br>On 6/23/21 at 2:25 p.m. a comprehensive medical record review was completed for Resident E. The record indicated Resident E was admitted to the facility on 3/5/20.<br><br>An imaging exam report indicated Resident E had a, "XR Chest PA AP" (an x-ray of the front and back of the chest) completed on 3/20/20 at 2:38 p.m. The reason for the exam indicated, "screening for TB".<br><br>A document titled, "Tuberculosis Testing and Vaccine Consents and Records" indicated, Resident E received a 2-step Mantoux (a test to detect the immunity developed against tuberculosis causing bacteria). The document indicated step 1 was given 4/8/20, and step 2 was given 4/23/20.<br><br>During an interview with the Care Service Manager (CSM) on 6/23/21 at 3:27 p.m., she indicated, all residents are required to have a TB test and a chest x-ray before they can move into the facility. There had been some residents whose move-in was delayed because they did not have their TB test and chest x-ray.<br><br>On 6/24/21 at 9:15 a.m., the CSM provided a policy titled, "Physical Examination", effective date 9/1/2016. The CSM indicated this was the current policy in use by the facility at that time. The policy indicated, "TB Screening. Residents must provide documentation of a negative TB screen to move in." | | **what corrective action will be taken?**<br>An audit of current resident tuberculin skin test records and chest x-ray results was completed on 07/15/21 by the CSM to ensure residents received a first and second step Mantoux and a chest x-ray prior to or upon move in. Any issues identified were corrected<br><br>**3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur?**<br>The CSM was re-educated on 7/15/2021 by the RDCS on the tuberculin skin test and chest x-ray regulation (Attachment 11).<br><br>**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The ED is responsible for sustained compliance. The CSM or designee will audit newly admitted resident tuberculin skin test and chest x-ray records weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure compliance. Results of the audit will be discussed in the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 | |

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| | | | consecutive months of compliance. Monitoring will be on-going.<br><br>**5. By what date the systemic changes will be completed**<br>Completion date: 7/24/2021 | |