STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155846	A. BUILDING 00 B. WING	12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREEN HOUSE COTTAGES OF CARMEL	616 GREEN HOUSE WAY CARMEL, IN 46032

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F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00368601. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00368601 - Unsubstantiated due to lack of evidence. Survey dates: December 8, 9, and 10, 2021 Facility number: 013753 Provider number: 155846 AIM number: 201362150 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 4 Medicaid: 32 Other: 18 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 17, 2021.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility or Management Group of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility respectfully requests paper compliance.	
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.			

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

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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			

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	must prohibit employees with a 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.			
	Based on observations, interviews, and record reviews, the facility failed to properly prevent and/or contain COVID-19 for 7 of 7 residents reviewed for infection control (Residents X, Y, Z, K, T, U, and V), and failed to ensure 2 of 5 staff members reviewed for infection control completed COVID-19 screening before entering a resident Cottage and beginning work (Cook 17 and CNA 18). Findings include: 1. During an interview, on 12/8/21 at 12:12 p.m., the Director of Nursing (DON) indicated during routine staff testing of unvaccinated staff, they found a positive staff member, Registered Nurse (RN) 7. She had worked in Cottages 2 and 3. They	F 0880	F 880 SS=E Infection Prevention and Control A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424 effective January 6, 2022. Green House Cottages of Carmel must include the following in their POC for the deficient practice cited at F880: **A.Specific/Immediate: Immediately implement specific plan for resident/residents/area/others identified in the deficiency to correct.** 1). The Director of Nursing (DON)	01/05/2022

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	completed outbreak testing and found 3 residents from Cottages 2 and 3 who were positive for COVID-19. They were Residents X, Y, and Z. On 12/9/21 at 10:33 a.m., a facility map was provided by the administration and reviewed. It indicated the COVID-19 positive residents were in Cottage 6, in 3 rooms. The residents on COVID-19 precaution were in Cottage 2, in 3 rooms. On 12/8/21 at 12:53 p.m., the entry door to Cottage 6 was observed. There were no signs indicating the entire Cottage was considered a COVID-19 red zone (an area of isolation requiring gowns and gloves for contact and droplet precautions). a. On 12/8/21, from 12:55 to 3:58 p.m., a continuous observation of the residents and staff of Cottage 6 was completed. On 12/8/21 at 12:55 p.m., Qualified Medical Assistant (QMA) 8 was observed wearing a blue disposable gown in the lobby. She was sitting in a chair near the lobby with no gloves on her hands. She was wearing a surgical mask first and an N95 mask on top of it. One strap of her N95 mask was hanging down by her chin. She was the only staff person in Cottage 6. On 12/8/21 at 1:01 p.m., the red zone was indicated by the contact/droplet precaution signs observed on 3 resident rooms. The small cabinet outside of each room had PPE inside. There were no boxes of gloves in or on the PPE cabinet. QMA 8 was observed entering, then exiting Resident X's room. She removed her gloves but wore the contaminated gown into the kitchen. She indicated there were gloves in the resident's rooms. She did not wash her hands before she pushed open the half door to the kitchen. She got		or Designee will educate the facility staff on isolation procedures, how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. 2.) Ensure staff are educated, with return demonstration, for hand hygiene and understanding when to perform hand hygiene. 3.) Ensure staff are educated to screen at the beginning of their shift for fever and respiratory symptoms, including, but not limited to, shortness of breath, new or changing cough, loss of taste/smell, and sore throat. For this education and return demonstration, the following resources will be used: · Facility policy: don and doff PPE · Facility policy: Hand Hygiene · Facility policy: Staff screening · CDC Guidance: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected Covid – 19	

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	ice from the kitchen refrigerator. On 12/8/21 at 1:04 p.m., QMA 8 was still wearing the contaminated gown she wore in Resident X's room and her surgical mask under her N95 mask. She entered the lounge area and interacted with Resident Y, trying to redirect Resident Y back to her room. On 12/8/21 at 1:06 p.m., QMA 8 was observed as she washed her hands with soap and water. On 12/8/21 at 1:10 p.m., QMA 8 put on a new gown, with no gloves. She wore her surgical mask under her N95 mask. She sat in chair near the lobby. On 12/8/21 at 1:12 p.m., QMA 8 entered Resident X's room, the resident indicated she was hungry and wanted something to eat. QMA 8 did not put gloves on before entering the room and came out wearing the contaminated gown and sat in chair near the lobby. Her surgical mask under her N95 mask. On 12/8/21 at 1:18 p.m., QMA 8 walked across the lobby and entered the medication room to call Resident Y's husband. She was still wearing the contaminated gown from Resident X's room. She touched the phone, and she used her bare hands to wheel Resident Y from her room to the entrance of the medication room, and gave the phone to Resident Y. Her surgical mask under her N95 mask. On 12/8/21 at 1:21 p.m., QMA 8 was still wearing the contaminated gown from Resident X's room, did not put on gloves and entered Resident Y's room again. She used her bare hands to open the closet to retrieve her red sweater. She brought the		· CDC Guidance: Sequence for Putting On Personal Protective Equipment (PPE) · CDC Resource: hand washing and sanitizer · Competency Tool: Personal Protective Equipment (PPE) from the American Association of Post-Acute Care Nursing (AAPACN) **B. Systemic** 1). A root cause analysis (RCA) was conducted by the Director of Nursing, to determine the root cause resulting in the facilities Infection Control citation. a). Through staff interviews, it was determined that staff developed a misunderstanding from education regarding PPE utilization in the red zone. The facility leadership team failed to ensure proper education was provided to staff working in the red zone. b). The solutions and systemic changes developed by the Director of Nursing: The Director of Nursing (DON), or Designee will educate the facility staff on isolation policy, how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator	

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	red sweater to Resident Y, who was sitting in front of the medication room. Using her bare hands, she rolled Resident Y's wheelchair to her room to put on the red sweater. She did not change gowns or put on gloves. Her surgical mask under her N95 mask. On 12/8/21 at 1:23 p.m., QMA 8 opened Resident Y's closet with her bare hands and offered Resident Y a choice of warmer clothing. QMA 8 touched a red sweater and a pink jacket. QMA 8 exited the room without removing her gown and did not have gloves on. Her surgical mask under her N95 mask. She sat in the chair near the lobby and sanitized her hands. On 12/8/21 at 1:25 p.m., QMA 8 entered Resident Y's room, she did not her change gown and did not put on gloves. Her surgical mask under her N95 mask. During an interview, on 12/8/21 at 1:35 p.m., QMA 8 indicated she had PPE in-service education about 2 months ago. On 12/8/21 at 1:59 p.m., QMA 8 took a pink sweater from Resident Y in the lobby and entered the resident's room. She opened the closet door with her bare hands and hung up the sweater. She was wearing the same contaminated gown, she did not put on gloves before touching the pink sweater, she did not wash her hands after hanging up the sweater after she exited resident Y's room. On 12/8/21 at 2:03 p.m., QMA 8 was observed removing her gown and washing her hands. She put on a new gown and no gloves, Resident K came into the lobby, and QMA 8 tried to redirect her back to her room. QMA 8 touched Resident K sweater with her bare hands, as she assisted the		devices, gloves, gown, and eye protection. For this education and return demonstration, the following resources will be used: · Competency Tool: Personal Protective Equipment (PPE) from the American Association of Post-Acute Care Nursing (AAPACN) · Facility policy: How to use PPE · Facility policy: Hand washing · CDC Guidance: Sequence for Putting On Personal Protective Equipment (PPE) · CDC Resource: Hand washing and sanitizer The DON, or Designee will re-educate the facility staff on the policy: Use of PPE While in the Facility The DON, or Designee will review with the facility staff: CDC Resource for Facemask Do's and Don'ts The DON, or Designee will post the CDC Resource for Facemask Do's and Don'ts throughout the facility as a visual reminder to the	

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	resident back to her room. She was not wearing gloves or a gown when she exited Resident K's room. QMA 8 washed her hands. On 12/8/21 at 2:13 p. m., QMA 8 entered Resident X's room. She was wearing a clean gown but no gloves. The resident asking about food. On 12/8/21 at 2:35 p.m., lunch arrived for Cottage 6 in a small green enclosed cart. QMA 8's surgical mask was observed under her N95 mask. Resident Y was offered lunch and refused. QMA 8 was observed touching Resident Y's wheelchair without gloves, then went back to the kitchen. She opened the kitchen door to enter. She did not wash her hands before getting lunch for Resident X. She did not put on a gown or gloves when she entered Resident X's room. She exited Resident X's room, entered the kitchen again and retrieved lunch for Resident K. She wore no gown or gloves when she entered Resident K's room. She did not wash her hands. She went back to the kitchen, with her bare hands she touched the kitchen's door, opened cabinets and found a coffee mug. She picked it up and touched the rim of the mug with several fingers. She pulled silverware from an open bin of disposable silverware on the counter. She entered Resident X's room again with no gown or gloves. She did not wash her hands and went back to the kitchen to retrieve a drink. She opened kitchen cabinets and found a small, non-disposable plastic cup, she poured cranberry juice in it for Resident X. On 12/8/21 at 3:08 p.m., Resident Y was in the lobby and indicated she was cold. QMA 8 did not wear a gown or gloves when she entered Resident Y's room. She used her bare hands to open the closet to retrieve the red sweater and pink jacket. Without putting on gloves, QMA 8 assisted		staff on the proper way to wear your facemask at all times. The DON, or designated facility leadership will conduct full facility / all department rounds at a minimum of daily to ensure staff are wearing face masks appropriately while in the facility and enforce corrective measures and education if deficiencies are observed. 2). The DON, and ED reviewed the LTC Infection Control Self-Assessment. Changes were made to so the assessment would now be an accurate reflection of the facility. This assessment will be submitted with the DPOC documentation. **C. Training:** 1). Per the LTC infection control assessment review and revision by the DON. The following training needs were identified and implemented by the DON to the facility IP and DON with training resources and polices provided and submitted as part of the DPOC documentation. - Standard Precautions - Appropriate mouth, nose, and eye protection (e.g., facemask) is	

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	Resident Y with putting on the pink jacket and zipped it up for her. She returned to Resident Y's room without a gown or gloves, touched the closet door handle with her bare hands and put the hanger inside. On 12/8/21 at 3:32 p.m., QMA 8 entered resident X's room, she was not wearing a gown or gloves. She sanitized her hands when she exited. On 12/8/21 at 3:38 p.m., Resident Y was in the lobby, she became upset and started crying. QMA 8 was observed touching with her without wearing a gown or gloves. Then, without washing her hands, QMA 8 went into the medication room and used her bare hands to touch the phone to call Resident Y's husband. He did not answer. During a continuous observation, on 12/8/21 from 3:40 to 3:45 p.m., QMA 8 removed Resident Y's pink jacket. She was not wearing a gown or gloves. The resident continued to become more upset, QMA 8 continued to touch the resident to comfort her. With her bare hands, she pushed Resident Y's wheelchair. Resident Y began clinging to QMA 8's arm and pulling on her clothes. The resident was still crying, QMA 8 was rubbing her shoulder and holding her bare hand. Then, leaning down to her face, she was touching both of the resident's shoulders for comfort. Resident Y was not wearing a mask. They both entered Resident Y's room. QMA 8 tried to distract the resident with a picture of her family. Resident Y was still very upset, raising her voice and crying, pulling on QMA's clothes. Resident Y followed QMA 8 in the medication room. On 12/8/21 at 3:45 p.m., Resident Z entered the lobby indicated she needed the toilet. Her lower body was completed exposed. She repeated		worn. The DON, IP or Designee will educate the facility staff on the policy: Use of PPE While in the Facility 1). Per the RCA completed by the DON and ED, the following training needs were identified and implemented by the DON with training resources and polices provided and submitted as part of the DPOC documentation. The Director of Nursing (DON),) or Designee will educate the facility staff on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. For this education and return demonstration, the following resources will be used: · Competency Tool: Personal Protective Equipment (PPE) from the American Association of Post-Acute Care Nursing (AAPACN) · Facility policy: How to use PPE · Facility policy: Hand washing · CDC Guidance: Hand washing	

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	several times to QMA 8 she needed to use the toilet. On 12/8/21 at 3:48 p.m., QMA 8 left Resident Y alone in medication room after she got Resident Y to stop pulling on her shirt and without gown or gloves walked with Resident Z to her room. On 12/8/21 at 3:53 p.m., QMA 8 was observed in Resident Z's room. She did not have a disposable gown on but wore gloves. On 12/8/21 at 3:58 p.m., QMA 8 indicated she had called the ED earlier to get more gowns for the Cottage and he did not answer. She indicated she should not have gone in the resident rooms without proper PPE. She indicated she should have called the Scheduler to try and get more gowns for the Cottage 6. b. On 12/9/21, from 10:03 to 11:54 a.m., a continuous observation of the residents and staff of Cottage 6 was completed. QMA 8 was observed putting on a gown but did not use hand sanitizer on her hands or put on gloves before entering Resident X's , Y's, and Z's rooms. Each time she would exit a resident's room, she removed her gown in the resident's room and sanitized her hands after she exited. At the next room she did not use hand sanitizer on her hands or put on gloves before entering the next resident's room. On 12/9/21 at 11:48 a.m., Resident Z exited her room. QMA 8 put on a gown, did not sanitize her hands or put on gloves and assisted the resident to a nearby bench. She was observed touching the resident's arm. Without washing or sanitizing her hands she opened a Styrofoam cup of oatmeal and squeezed it out into a non-disposable bowl. Then, with her bare hands, she opened the door		· CDC Guidance: Sequence for Putting on Personal Protective Equipment (PPE) · CDC Resource: Face masks do's and don'ts The DON, IP or Designee will re-educate the facility staff on the policy: Use of PPE While in the Facility The DON, IP or Designee will review with the facility staff: CDC Resource for Facemask Do's and Don'ts **D. Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained.** 1). The DON, or designated facility leadership will conduct full facility / all department rounds at a minimum of daily M-F for 6 weeks and until compliance is maintained: to ensure staff are wearing PPE appropriately while in the facility, face masks are stored in an appropriate manner, and enforce corrective measures and education if deficiencies are observed 2). The DON, or designated facility leadership will complete daily visual rounds throughout the facility M-F to ensure staff are	

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	to the kitchen and opened the microwave and reheated Resident Z's breakfast. She assisted Resident Z from the bench to a dining room chair and assisted her with eating. She did not wash her hands or wear gloves. The Cottage phone rang at 11:54 a.m., QMA 8 left the resident's side and answered the phone. She returned and assisted Resident Z with eating. In-service training, titled, "Hand Hygiene/Hand Washing, dated 10/25/21, was provided by the DON during the survey, at an unknown date or time. A review of the in-service indicated it was provided by Physical Therapy Assistant (PTA) 16. A signature page indicated QMA 8 attended, with 29 other staff members. In-service training, titled, "F880 Infection Control, Hand Hygiene, Donning and Doffing PPE," dated 10/28/21, was provided by the DON during the survey, at an unknown date or time. The presenter area was blank. A signature page indicated QMA 8 attended, with 27 other staff members. c. On 12/9/21, from 2:15 to 4:00 p.m., a continuous observation of the residents and staff of Cottage 2 was completed. On 12/9 at 2:15 p.m., Certified Nursing Aide (CNA) 10 was observed entering Resident T's room. She completed proper donning and doffing of PPE but indicated she did not wash her hands in the resident's room or use hand sanitizer when she exited. On 12/9/21 at 1:36 p.m., Resident U was observed exiting her room with non-disposable dishes on her lap. She was in an isolation room as suspected COVID-19. She wore a surgical mask. She was able to move herself slowly in her wheelchair. She		practicing appropriate Infection Control Practices and ensure the CDC Resource for Facemask Do's and Don'ts continues to be posted throughout the facility. This will occur for 6 weeks and until compliance is maintained. **E. Quality Assurance and Performance Improvement (QAPI):** The IP Nurse/Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 6 months. The facility through the QAPI program will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	slowly passed, within a few feet of Resident V who was not wearing a mask. CNA 15 walked past her and Resident V. When Resident U got to the dining room she was talking with the Dietary Manager (DM). She gave him the dishes to return to the kitchen. She indicated the staff left them in her room. CNA 15 returned the resident back to her room at 1:41 p.m. On 12/9/21 at 2:37 p.m., Licensed Practical Nurse (LPN) 12 indicated staff should not have entered a COVID-19 or suspected COVID-19 room without proper PPE of a disposable gown, an N95 face mask, face shield and gloves. To exit a COVID-19 or suspected COVID-19 room, take off the disposable gown by folding inward, remove your gloves, and wash your hands. She indicated staff should have completed hand hygiene before and after caring for a resident. If a COVID-19 or suspected COVID-19 resident insisted on exiting their room, she indicated she would have put a mask on the resident and kept them 6 feet away from any other resident, then try to redirect again later. On 12/10/21 at 1:42 p.m., CNA 15 indicated the first time she saw Resident U in the hallway beside Resident V she did not realize it was her. When she did, she took her back to her room. On 12/10/21 at 2:00 p.m., the DM indicated he recognized Resident U as a suspected COVID-19 resident and should have assisted her back to her room then. He went to the dumpster and threw away the non-disposable dishes Resident U had given him. During an interview, on 12/9/21 at 12:09 p.m., the Executive Director (ED) indicated the facility did not have a shortage of PPE. They were well			

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	supplied. During an interview, on 12/9/21 at 12:22 p.m., the DON indicated staff should have been donning and doffing PPE appropriately with all required PPE. When entering a COVID-19 positive room, wearing a surgical mask under a one-time use N95 mask was appropriate. If a resident would leave their COVID-19 positive room, the staff should have encouraged them to wear a mask and return to their room. The COVID-19 positive residents should not have been within 6 feet of each other. The staff should have continued to verbally ask them to wear masks and return to their rooms. The DON indicated the only dementia resident in Cottage 6 was Resident Z. During an interview, on 12/9/21 at 12:31 p.m., the DON indicated regarding hand hygiene, she encouraged hand washing between each resident care event. During an interview, on 12/10/21 at 2:08 p.m., the DM indicated regarding Cottage 6's COVID-19 positive residents, he indicated the staff should not be using plastic non-disposable cups or non-disposable ceramic mugs for the residents. There was a sufficient supply of disposable cups in the Cottage. The resident's disposable silverware should not have been pulled from an open bin of non-rolled silverware. Rolled silverware was appropriate for Cottage 6 residents. During an interview, on 12/10/21 at 3:07 p.m., the DON indicated all staff should have been following the facility policies and State and Federal guidelines. A current policy, titled, "Personal Protective			

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	Equipment (PPE) Types and Uses of," dated 2016, was provided by the ED, on 12/8/21, during the entrance conference. A review of the policy indicated, " ...All community team members are expected to used personal protective equipment (PPE) as described ...Gloves will be worn whenever there is the opportunity that the tean [sic] nenver [sic] will come in contact with ...potentially infectious material ...Hands are to be washed each time gloves are removed ...gowns are to be worn whenever the team member could be at risk for contamination of their clothing or body by ...potentially infectious materials ...." A current policy, titled, "Handwashing/Hand Hygiene," dated August 2015, was provided by the ED, on 12/8/21, during the entrance conference. A review of the policy indicated, " ...This facility considers hand hygiene the primary means to prevent the spread of infections ...All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors ...Use an alcohol-based hand rub ...before and after direct contact with residents ...After contact with a resident's intact skin ...After removing gloves ...Before and after entering isolation precaution settings ...before and after eating or handling food ...before and after assisting a resident with meals ...Hand hygiene is the final step after removing and disposing of personal protective equipment ...The use of gloves does not replace hand washing/hand hygiene ...Single-use disposable gloves should be used ...When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions ....." A current policy, titled, "Isolation - Initiating Transmission-Based Precautions," dated January			

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	2012, was provided by the ED, on 12/8/21, during the entrance conference. A review of the policy indicated, " ...When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee) shall: Ensure that protective equipment (i.e,. gloves, gowns, masks, etc.) is maintain near the resident's room so that everyone entering the room can access what they need ...Ensure that an appropriate linen barrel/hamper and waste container, with appropriate liner, are place in or near the resident's room ...." 2. On 12/10/21 at 9:45 a.m., a Cottage was reviewed for staff COVID-19 screening prior to entering the resident Cottage and beginning work. There were 5 staff members working in the Cottage. Cook 17 and CNA 18's names were not on the COVID-19 screening paper in the entry way to the Cottage. They did not complete the COVID-19 screening tool questionnaire and take their temperatures prior to entering the Cottage. During an interview, on 12/10/21 at 9:55 a.m., Cook 17 indicated she did not do the COVID-19 screening or take her temperature prior to starting to work in the kitchen preparing meals for the residents. She was running late. She was observed standing in the kitchen. During an interview, on 12/10/21 at 10:00 a.m., CNA 18 indicated she did not do the COVID-19 screening or take her temperature prior to starting to work with the residents. She indicated she did not know she was supposed to COVID-19 screen before beginning work. On 12/10/21 at 2:00 p.m., the Dietary Manager (DM) indicated all kitchen staff should have completed the COVID-19 screening questionnaire			

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	and taken their temperature before starting work in the Cottages. Current guidelines posted online, from the Indiana Department of Health (IDOH), titled, "Long Term Care Novel Coronavirus (COVID-19), dated 12/14/21, indicated, " ...Visitors and healthcare personnel (HCP) are the most likely sources of introduction of the virus that causes COVID-19 in a facility. The Indiana State Department of Health follows guidance from the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) ...." Current guideline posted online, from the Centers for Disease Control and Prevention (CDC), titled, "Infection Control Guidance," dated 9/10/21, indicated, " ...Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic ...Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection ...Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work ...." 3.1-18(b)(2)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative			

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	receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum,			

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	the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to ensure prophylactic measures were taken or documented as refusals to prevent pneumonia or influenza for 2 of 5 residents reviewed for pneumonia and influenza vaccinations (Resident X and T). Findings include: 1. On 12/8/21 at 3:25 p.m., Resident X's record was reviewed. She was admitted on 9/27/21. Her electronic medical record (EHR) showed she did not receive the pneumonia or influenza vaccinations. Her pertinent diagnoses included, but were not limited to, disseminated mycobacterium avium-intracellular complex (bacterial lung disease), bronchiectasis (chronic, dilated bronchial tubes with small pockets that are susceptible to infection), and heart failure. On 12/10/21 at 12:10 p.m., the Director of Nursing (DON) provided Resident X's October Medication Administration Record (MAR). She indicated on 10/12/21 the nurse did not give the influenza vaccination to Resident X because they were waiting on an influenza consent. 2. On 12/9/21 at 3:15 p.m., Resident T's record was reviewed. She was admitted on 6/25/21. Her EHR	F 0883	**F883 SS=D Influenza and Pneumococcal Immunizations** **·What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** It is the practice of this facility to ensure prophylactic measures are taken or documented as refusals to prevent pneumonia or influenza. The medical record for elder T and X was updated to reflect that both elders received education regarding benefits and potential side effects of immunization and their vaccination status. **·How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** A 100% audit was conducted by the Director of Nursing to ensure each elder received education regarding benefits and potential side effects of immunization and	01/05/2022

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	showed she did not receive the pneumonia or influenza vaccinations. Her pertinent diagnoses included, but were not limited to, asthma (reactive airway disease), Alzheimer's disease (progressive mental deterioration), and bipolar disease psychiatric illness of maniac and depressive episodes). On 12/10/21 at 12:10 p.m., the DON provided Resident T's October MAR. She indicated on 10/12/21 the nurse did not give the influenza vaccination to Resident T because they were waiting on an influenza consent. On 12/10/21 at 11:11 a.m., the DON indicated the facility staff would review the MARs to find the vaccination administration dates. The previous administration left without scanning in all the 2021 vaccinations. She indicated they would go through the documents to provide the current pneumonia and influenza vaccination information for Residents T and X. On 12/10/21 at 1:20 p.m., the DON indicated they had reviewed the unscanned documents and had provided all the influenza information. During an interview, on 12/10/21 at 3:07 p.m., the DON indicated all staff should have been following the facility policies and State and Federal guidelines. A current policy, titled, "Influenza Vaccine," dated November 2012, was provided by the DON on 12/10/21 at 3:10 p.m. A review of the policy indicated, " ...All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated		their vaccination status is documented in the medical record. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The DNS and or designee will provide education to staff related to our immunization policy and procedure. Any staff that fail to comply with the information delivered in the in-service will be further educated and/or progressively disciplined as indicated. ·**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; and** The Director of Nursing and/or designee will review immunizations for new admissions once weekly, times 6 months or ongoing until 100% compliance achieved. This deficient finding will be monitored by the Executive Director and/or designee through the observation and review of audit tools. The findings of the audits will be reviewed, in the monthly QAPI times 6 months or ongoing	

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	with vaccination against influenza ...For those who received the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's/employees medical record ...The Infection preventionist will maintain surveillance data on influenza vaccine coverage ...." 3.1-18(b)(5)		until 100% threshold is achieved.	