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	05/20/2021

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00348988, IN00349905, IN00350758, IN00351036 and IN00353622. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00348988 - Substantiated. Federal/State deficiencies related to the allegations are cited at F584. Complaint IN00349905 - Substantiated. Federal/State deficiencies related to the allegations are cited at F732 and F880. Complaint IN00350758 - Substantiated. Federal/State deficiencies related to the allegations are cited at F563, F584 and F697. Complaint IN00351036 - Substantiated. Federal/State deficiencies related to the allegations are cited at F563, F584, and F697. Complaint IN00353622 - Substantiated. Federal/State deficiencies related to the allegations are cited at F563 and F625. An unrelated deficiency was cited at F812. Survey dates: May 14, 16, 17, 18, 19 and 20, 2021 Facility number: 013753 Provider number: 155846 AIM number: 201362150 Census Bed Type: SNF/NF: 50	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.	

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

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	Total: 50 Census Payor Type: Medicare: 3 Medicaid: 37 Other: 10 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on May 27, 2021.			
F 0563 SS=E Bldg. 00	483.10(f)(4)(ii)-(v) Right to Receive/Deny Visitors §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of			

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	residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. Based on observation, interview and record review, the facility failed to provide immediate access by the immediate family, other relatives or others visiting to 6 of 9 residents reviewed for visitation rights, subject to reasonable clinical and safety restrictions. (Residents D, E, G, J, K and L) Findings include: 1. During a telephone interview, on 5/17/21 at 3:45 p.m., Resident D's friend indicated she was originally told she could not visit the resident because she was not a family member. The resident did not have family members in this state. She was a close, long-time friend, and the only person who could visit the resident regularly. After she got in touch with the power of attorney (POA), the facility said she was allowed one visit in a room the resident "hated". It was a library in the front of the cottage with windows. The resident did not like it because the room was cold. The friend was not allowed to go into the resident's room. The family had put together a scrapbook of pictures the friend wanted to show the resident. The facility would not let her share the pictures with the resident because they said they had no way to clean the scrapbook. Beginning today, she could visit three times a week between 10:00 a.m. and 4:00 p.m. They were not allowed to schedule visits after 4:00 p.m. or on Saturdays or Sundays.	F 0563	F 563 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** We offer open visitations to all Elders family and friends. **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.** All Elders have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the Deficient practice does not recur;** A new visitation policy was implemented on May 17, 2021, that allows open visitations. The staff was educated on the new policy.	06/19/2021

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	Resident D's medical record was reviewed on 5/20/21 at 10:00 a.m. Diagnoses included, but were not limited to, dementia and chronic pain. Resident D's quarterly minimum data set (MDS) assessment, dated 4/09/21, reflected she had a severely impaired cognitive status. 2. During a telephone interview, on 5/18/21 at 10:50 a.m., Resident E's daughter indicated her brother was the resident's power of attorney. She was her essential care giver prior to her admission to this facility from an independent living facility in February 2021. Resident E's daughter did everything for her: laundry, shopping, housekeeping, doctor appointments and companionship. The resident was independent with her activities of daily living (ADLs), but the daughter helped her with her hair dryer because it was heavy and hard for her to lift above her head. Prior to yesterday when visitation was relaxed, she had to schedule ahead for a one-hour visit. She had to drive an hour to get there. She asked to be able to stay longer than an hour and to be designated an essential care giver but was denied. The daughter indicated, it "just kills me they don't recognize essential care givers." The resident was having difficulty making friends with the other residents. The resident called her every day complaining she was lonely. The resident missed the companionship the daughter was able to provide prior to the COVID-19 pandemic. Resident E's medical record was reviewed on 5/17/21 at 2:34 p.m. Diagnoses included, but were not limited to, anxiety disorder, major depressive disorder and dementia.		**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.** Social Service/designee will monitor/audit any reported visitation concerns to ensure all staff compline with the policy. 4 x weeks, then biweekly for 2 months, then monthly for 3 months. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of audits. /p>	

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	Resident E's admission MDS assessment, dated 2/25/21, reflected she had a severely impaired cognitive status. 3. During an interview, on 5/16/21 at 5:50 p.m., two daughters of Resident G were leaving Cottage 5. They indicated the resident fell on 5/14/21. The Director of Nurses (DON) told them they could visit, now, anytime they wanted, while they addressed the resident's fall. Prior to her fall, they were prohibited from visiting as much as they felt they needed. First, they were told they could visit twice a week, for one hour at a time, and with no more than two people at a time. Then visitations increased to three times a week. No one under 18 was allowed. The resident had young grandchildren who would like to visit. They were upset because as many as five painters at a time were allowed in the cottage, and the facility brought in Indy 500 festival princesses to visit the residents, but the family could not visit. They were not allowed to visit residents in the back porch because they were told other residents might want to use the porch. They could not visit on the front porch because they were told it was close to the cottage entrance, and people came and went near there. There were no other designated outside visiting areas. They were not allowed excursions (trips away from the facility lasting less than 24 hours) for about 18 days after the Centers for Disease Prevention and Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance allowed it. For excursions, they had to give 24-hour notice. They asked to be essential care givers because they wanted to be sure the resident was served warm food she would eat. She especially needed help eating after injuring her arm during her fall on 05/14/21. They were denied.			

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	Resident G's medical record was reviewed on 5/20/21 at 3:09 p.m. Diagnoses included, but were not limited to, major depressive disorder, anxiety disorder, pain in left shoulder, need for assistance with personal care and age-related physical debility. Resident G's significant change MDS assessment, dated 3/04/21, indicated she had a moderately impaired cognitive status. She required supervision and setup assistance for eating. 4. During an observation and interview, on 5/14/21 at 3:54 p.m., a family member of Resident J was escorting the resident from her car to Cottage 3. The family member indicated she was bringing the resident back from a doctor's visit. A staff member greeted the resident and her family member at the door to the cottage. The family member asked to escort the resident to her room, but the staff member refused to give her entrance into the cottage. The family member again asked to just take the resident to her room and then leave immediately. The resident indicated to the family member she wanted her to take her to her room and appeared sad when the staff denied entrance to the family member. Resident J's medical record was reviewed on 5/20/21 at 3:12 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and major depressive disorder. Resident J's quarterly MDS assessment, dated 3/05/21, reflected she had a severely impaired cognitive status. 5. During an observation and interview, on			

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	5/14/21 4:01 p.m., Resident K was sitting on the couch of the common area of Cottage 3. Her son was sitting next to her. Her daughter-in-law was sitting in a chair nearby. The son was tearful. He indicated it was the first, in-person visit he had with his mother since the beginning of the COVID-19 pandemic. They were following the rules and previously were only allowed visits through the window. Because of her dementia, she did not recognize the family through the window. When asked if he tried to visit his mother in-person prior to today, he only volunteered they followed the rules. Resident K's medical record was reviewed on 5/20/21 at 2:54 p.m. Diagnoses included, but were not limited to, dementia and major depressive disorder. Resident K's annual MDS assessment, dated 4/30/21, reflected she had a severely impaired cognitive status. 6. During an interview, on 5/19/21 at 10:52 a.m., Resident L's daughter indicated she was told a couple of times she could not visit because there were too many other people visiting residents. She wanted to come, on Sunday 5/16/21, and the facility would not let her because there were too many other people visiting relatives. They were required to give 24-hour notice they wanted to visit. Resident L's daughter did her laundry. On Wednesday 5/12/21, she saw the resident and took her laundry. She wanted to come on 5/16/21 to bring back the laundry, but the Life Enrichment Coordinated sent her an e-mail saying she could not come. Today, they are only allowed to visit three days a week and not after 4:30 p.m. Resident L's daughter did not get home from work until 6:00 p.m.			

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	Resident L's medical record was reviewed on 5/20/21 at 3:17 p.m. Diagnoses included, but were not limited to Alzheimer's disease, major depressive disorder, and anxiety. Resident L's quarterly MDS, dated 2/18/21, reflected she had a severely impaired cognitive status. During an interview, on 5/14/21 at 3:00 p.m., the Executive Director (ED) indicated the facility did not allow family members to be designated as essential care givers because the facility could meet the needs of the residents. They were currently allowing family members to visit residents no more than three times a week for one hour in the resident's room or in a designated area, such as the cottage libraries. They did not want more than a total of 10 visits per cottage per day to manage social distancing. There were five cottages occupied with residents. They rotated visitations so no more than two elders had visitors at the same time. Visitors could also go to the cottage courtyards but were not required to conduct the visits outside. People who came to visit but were not on the pre-printed schedule were directed to the administration office. The ED indicated approximately 90 percent of the residents were vaccinated. There were no residents or staff who currently had the COVID-19 virus. They adjusted their visitation policies on the county positivity rate, which she indicated was currently 5.61 percent. During an interview, on 5/16/21 at 5:04 p.m., Qualified Medication Aide 2 indicated a visitor had to be on the schedule "because some families will try to sneak in." She demonstrated a schedule was posted in the nurses station.			

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The facility's "In-Person Visitor Schedule," for Sunday 5/16/21, reflected no visits were scheduled before 9:00 a.m. or after 5:00 p.m. Visits were scheduled for one-hour. 14 residents were scheduled to receive visitors. Two residents were scheduled to have excursions.

An e-mail, dated 3/25/21, from the ED to 75 recipients indicated "Starting next week, we are trying for visits two times a week for an hour, two family members at a time...Remember you can take your loved one out on an excursion but on the day of the excursion you may not have an indoor visit. This will allow family members the chance to visit if they are unable to take their loved one out. Our cottages are smaller than a nursing facility so we can only allow so many people in the cottage at one time...."

An e-mail, dated 4/13/21, from the ED to the same recipients indicated "We are now doing three times a week visitation up to an hour visit. Please remember to follow the guidelines during your visit. With the decrease in COVID it will not be long before we are fully open for visitation."

An e-mail, dated 5/7/21, from the ED to the same recipients indicated in red letters and all capitals: "PLEASE REMEMBER YOU MUST MAKE AN APPOINTMENT TO VISIT. AT THIS TIME, IT'S 3 TIMES A WEEK FOR AN HOUR. IF YOU SHOW UP WITHOUT AN APPOINTMENT YOU MAY BE TURNED AWAY...The Indy 500 Princess dropped into visit our Elders today...."

During an interview, on 5/18/21 at 2:15 p.m., the ED indicated she presented an updated facility

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	policy on visitation at a Zoom meeting on 4/20/21, attended by the Family Council. The facility's "Visitation Guidelines," undated and provided by the ED on 5/17/21 at 1:54 p.m., indicated "...To allow for indoor visitation guidelines, certain requirements must be met. Requirements are: There have been no new facility-onset COVID-19 cases in the past 14 days among residents. Visitation area (Library) within the community is established and allow for social distancing between elders [residents] and visitors. You may also visit in Elder's room. You must stay in the visitation area or Elder's room. Indoor visitation will be offered at all times of the day in an hour increment. Maximum of 2 visitor per Elder 3 times a week...Visitors may be allowed if: scheduled appointment is completed prior to arrival to community...Facility might need to limit the total number of visitors in the facility at one time to maintain recommended core principles of infection control...Outdoor visitation: Facilities should create accessible and safe spaces for outdoor visitation...Whenever possible, allow up to one or two hours and two visitors per resident...Excursions (leaving the facility for less than 24 hours in duration, e.g. family home, church, wedding, funeral, etc.)...Residents who are not independently mobile may be escorted on outdoor excursions if all precautions are taken (i.e., social distancing of at least six feet, masks, and hand hygiene) they do not require transition based precautions upon return...." The Indiana State Department of Health (IDOH) guidance, titled "Essential Family Caregivers in Long-Term Care Facilities," dated 6/5/20, reflected "...Recognizing the critical role family members and other outside caregivers (e.g.,			

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	friends, volunteers, private personal caregivers) often have in the care and support of residents, it is recommended that LTCFs [long term care facilities] consider designating as Essential Family Caregivers (EFCs) those family members and other outside caregivers who, prior to visitor restrictions, were regularly engaged with the resident at least two or more times per week to provide companionship and/or assist with activities requiring one-on-one direction...." The IDOH guidance, titled "Long-term Care Facilities Guidelines in Response to COVID-19 Vaccination," dated 5/03/21, reflected "...Outdoor Visitation. Facilities should create accessible and safe spaces for outdoor visitation... Indoor Visitation. Indoor visitation should be allowed at all times. A facility may create a policy for normal visitation hours, length of visits, the number of visitors per resident, and the number of visitors at any one time to protect the health and security of residents and staff. Long-term care facilities should work with residents if any visitors are not available during normal visitation hours to ensure proper accommodations are provided, consistent with resident preference...Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission. These scenarios include limiting indoor visitation for unvaccinated residents, if the nursing home's COVID-19 county positivity rate is greater than 10 percent and less than 70 percent of residents in the facility are fully vaccinated ...Long-term care facilities should enable visits to be conducted with an adequate degree of privacy. Privacy may inherently be limited when the visit is occurring in an open			

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	visitation space within the facility...Long-term care facilities are not required to perform continuous observation/supervision of each visitor and visitation in order to maintain compliance with core principles of infection control...." This Federal tag relates to complaints IN00351036, IN00350758 and IN00353622. 3.1-8(b)(7)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that			

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	are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on interview and record review, the facility failed to exercise reasonable care for the protection of property from loss or theft when the facility failed to accurately inventory and document the personal belongings and failed to follow their policy to obtain signatures from the residents or their representatives to indicate agreement on the inventory of personal items for 3 of 3 residents reviewed for property (Residents E, C, and Q). Findings include: 1. During a telephone interview, on 5/18/21 at 10:46 a.m., Resident E's daughter indicated the following items were missing from her mother's room: approximately $250.00 worth of hearing aid batteries, a bathroom scale and six socks. They found the blue calico bag which held the batteries, but not the batteries. Other items which were missing but later found included a painting, tall ceramic urn, porcelain teacups and a gold bangle bracelet. The facility told her they inventoried everything. They offered to replace	F 0584	="" p**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **When a family or elder reports any missing items, if unable to find the facility replace the items or the family replaces, and the facility reimburses them. There were no reports, of missing batters, bathroom scale or sock.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.** **All elders have the potential to be affected.What measures will be put into place and what systemic changes will be made to ensure that the Deficient practice does not recur;How**	06/19/2021

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	155846	A. BUILDING 00 B. WING	05/20/2021

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	the socks, but not the bathroom scale or hearing aid batteries. During an observation, on 5/19/21 at 3:11 p.m., Resident E was sitting in her room reading the facility newsletter. No bathroom scale was observed in her room. Resident E's medical record was reviewed on 5/17/21 at 2:34 p.m. Diagnoses included, but were not limited to, anxiety disorder, major depressive disorder and dementia. Resident E's admission Minimum Data Set (MDS) assessment, dated 2/25/21, reflected she had a severely impaired cognitive status. Resident E's Personal Item Inventory, dated 2/23/21, did not include a bathroom scale, hearing aid batteries, a painting, an urn or teacups. The form had an illegible, undated staff signature. There was no resident or resident representative signature. During an interview, on 5/19/21 at 3:08 p.m., Certified Nurse Aide (CNA) 4 indicated she had not seen a bathroom scale or hearing aid batteries in Resident E's room. During an interview, on 5/19/21 at 3:08 p.m., Licensed Practical Nurse (LPN) 18 indicated she had not seen $250.00 worth of batteries for Resident E. The LPN helped the resident change the batteries every Saturday and said she had plenty. She demonstrated they stored her batteries in the nurses' medication cart. An observation, at that time, revealed the resident had 12 hearing aid batteries. 2. An e-mail from the family council president to		**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. Medical Records/designee will audit all new admission to ensure the Personal Item Inventory sheets are complete with a signature from elder or family. The audit will be completed on all new admissions for 6 months. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of audits.** **Date of Compliance: June 19,2021** ="" p="">	

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	the Indiana Statement Department of Health, dated 5/18/21, reflected Resident C's family member reported she was missing a Samsung cell phone. Three attempts to contact the resident's family member were unsuccessful. During an observation and interview, on 5/18/21 at 4:44 p.m., CNA 4 indicated she had not seen Resident C without her cell phone. She used it frequently to call family. Resident C's Samsung cell phone was on her bedside table being charged. Resident C's medical record was reviewed on 5/19/21 at 3:15 p.m. Diagnoses included, but were not limited to, cognitive communication deficit, need for assistance with personal care, bipolar disorder and major depressive disorder. Resident C's quarterly MDS assessment, dated 4/06/21, indicated she had a moderately impaired cognitive status. Resident C's Personal Item Inventory, dated 3/12/21, was signed by CNA 3. The form indicated the resident had a phone but did not indicate what type of phone it was. There was no resident or resident representative signature. 3. Resident Q's medical record was reviewed on 5/20/21 at 3:15 p.m. Diagnoses included, but were not limited to, stroke, dementia and repeated falls. Resident Q's quarterly MDS assessment, dated 3/08/21, reflected she had a severely impaired cognitive status. Resident Q's Health Status Note, dated 4/05/21, indicated her daughter took her to a cardiologist			

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	appointment at 1:30 p.m. At 5:30 p.m., the daughter called the facility to let them know she was being admitted to the hospital for possible pneumonia. Resident Q's Personal Item Inventory, dated 03/12/21, was signed by CNA 3. There was no resident or legal representative signature. During an interview, on 5/20/21 at 4:15 p.m., the Executive Director (ED) indicated the resident did not return to the facility because the family transferred her to another facility. During an interview, on 5/20/21 at 11:00 a.m., the ED indicated she thought staff were responsible for inventorying resident property at admission, when items were brought or removed from the residents' rooms and at their discharge. They reviewed Resident E's, C's and Q's records and determined there were no other records with the residents' or representatives' signatures or with updates to their inventory. There was no inventory of Resident C's property prior to 3/12/21, of Resident Q's inventory prior to 3/12/21 and of Resident Q's property at discharge on or around 4/05/21. A current facility policy, titled "Admitting the Resident: Role of the Nursing Assistant," dated September 2013 and provided by the ED on 5/30/21 at 3:30 p.m., reflected the following. "...Inventorying the Resident's Personal Effects... 4. Inventory all clothing, equipment, valuables, etc. Record: a. the quantity of each item; b. the description of each item; and c. other identifying factors as necessary or appropriate. 5. When all personal items have been inventoried and recorded on the Inventory of Personal Effects record, sign your name and title and instruct the			

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	family member that witnessed the inventory to also sign the form...7. Using the indelible ink marker, mark each item of clothing with the resident's first and last name...13. Inform the family that any additional items brought to or removed from the facility must be reported to the supervisor so that the inventory record can be kept current...." This Federal Tag relates to Complaint IN00350758, IN00351036, IN00348988. 3.1-9(g)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.			

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	§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to provide written information regarding their bed-hold policy to 1 of 3 residents (or their resident representative) reviewed for discharges before transferring a resident to the hospital. (Resident Q) Finding includes: Resident Q's medical record was reviewed on 5/20/21 at 3:15 p.m. Diagnoses included, but were not limited to, stroke, dementia and repeated falls. Resident Q's quarterly Minimum Data Set assessment, dated 3/08/21, reflected she had a severely impaired cognitive status. Resident Q's health status note, dated 4/05/21, indicated her daughter took her to a cardiologist appointment at 1:30 p.m. At 5:30 p.m., the daughter called the facility to let them know she was being admitted to the hospital for possible pneumonia. Resident Q's Bed Hold Policy, signed by her power of attorney on 11/28/20, included, but was not limited to, the following "...When an elder is hospitalized for any condition, or leaves [the facility] on a therapeutic leave or for any other reason, the elder or elder's representative may request that the elder's bed be reserved during this time. This is known as a 'bed hold'..."	F 0625	F 525What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Bed hold policy will be given to any elder leaving the facility.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. All elders have the potential to be affected.What measures will be put into place and what systemic changes will be made to ensure that the Deficient practice does not recur; The staff will be educated on the bed hold policy and procedure. A bed hold policy will be mailed to all families.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. Social Service/designee will audit all elder coming and going chart to ensure the bed hold policy and procedure is being followed. The audit will be done on all residents entering or leaving the facility for 6 months. The results of the audit	06/19/2021

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	During an interview, on 5/20/21 at 4:20 p.m., the Executive Director (ED) indicated no bed-hold policy was given to Resident Q or the resident's representative because the Social Worker misunderstood when the bed-hold policy should be given. She thought it was given at admission and she did not need to give it again if the resident was discharged to a hospital. During an interview, on 5/20/21 at 4:25 p.m., the Social Services Director indicated she scanned Resident Q's record and did not find a bed-hold policy was given to her when she transferred to the hospital. The only signed receipt of the bed-hold policy in her record was signed by her power of attorney in November 2020. She indicated the Business Office/Marketing department provided the bed-hold policy to residents at admission. She was not aware she was supposed to provide it again when a resident went to the hospital. She had not been providing the bed hold policy to residents transferring to the hospital. A current facility policy, titled "Move In, Transfer and Move Out Policy," dated 03/01/01 and provided by the ED on 5/20/21 at 11:45 a.m., indicated "...At the time of move in, transfer to another health care facility or overnight visits outside the home, the elder and/or their legal representative will be provided with information on how to hold the elder's [resident's] current suite during their absence...." This Federal tag relates to complaint IN00353622. 3.1-12(a)(25)(B) 3.1-12(a)(26)		will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of audits. **Date of Compliance: June 19, 2021**	

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F 0697 SS=G Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review, the facility failed to provide effective pain management in accordance with the resident's comprehensive care plan for 1 of 3 cognitively impaired residents reviewed experiencing pain. (Resident D) This resulted in Resident D having impaired mobility, mood, poor quality of life and increased the risk of pressure ulcers. Finding includes: During a telephone interview, on 5/17/21 at 3:45 p.m., Resident D's friend indicated the resident had no family nearby. She was a long-time friend and the only person able to visit the resident on a regular basis. Since before 4/27/21, she observed Resident D had pain in her hips and knees from prior hip surgery. She would not unlock her knees because of her pain. She did not have pillows or other devices to place between her legs for comfort or to protect her skin when she was in bed. She had not seen the sores, but staff told her the resident had sores on her knees because they were locked so tightly together. When she talked to staff about her legs, the only reply she received was "we're trying to manage her pain." The resident was so anxious and in pain, she cried all the time. She said things like, "I'm dying. I don't want to die. Please help me." When she was in pain, she became agitated and	F 0697	**F697** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident D's medical records were reviewed by NP, hospice and facility, pain assessment completed orders adjusted as needed. **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.** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the Deficient practice does not recur;** Nursing staff will be educated on the policy and procedure on pain assessments. A baseline pain	06/19/2021

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	confrontational with staff. She sometimes screamed when the friend just touched the wheelchair. She did not want to be touched or eat due to pain. During an observation and interview, on 5/20/21 at 2:25 p.m., with Nurse Practitioner (NP) 17, Resident D was lying on a low air loss mattress with wedges at the top right, and lower left and right sides of the bed. The foam insert for the wedge on the top left side of the bed was still on the chair across the room. The resident's right knee was bent across her left leg. The resident was holding onto the leg. NP 17 indicated there was a scar on her left leg, probably from lying that way for so long. She observed a red area on the left leg under the right knee. When the NP tried to separate the legs to view under the right leg, the resident yelled out "Ow". The NP was not able to separate the leg to view the skin underneath without inducing pain. The NP said they definitely needed to do something proactive to prevent skin breakdown. Resident D's medical record was reviewed on 5/20/21 at 10:00 a.m. Diagnoses included, but were not limited to, osteoporosis, dementia, muscle weakness, presence of right artificial hip joint and chronic pain. Resident D's quarterly Minimum Data Set (MDS) assessment, dated 4/09/21, indicated she had a severely impaired cognitive status. She had no behavior symptoms and had not resisted care. She required extensive assistance by one person for bed mobility, transfers, dressing, toileting and personal hygiene. She was totally dependent on one person for bathing. She did not walk. The MDS documented she had no pain and no significant weight loss in the last one month or		assessment will be competed on all Elders. **How the corrective actions will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place** The DON/Designee will monitor nurses' notes, order, and any change of condition in morning clinical meetings 5 times a week x 2 months then 3 times a week x 4 months, to ensure all pain is address. /b> **/b>**	

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	six months. She was at risk for developing pressure ulcers but had no unhealed pressure ulcers. Resident D's comprehensive care plan, initiated on 8/08/18, indicated she had chronic pain. Approaches included, but were not limited to, administer analgesia as per orders, anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Notify the physician and hospice if interventions were unsuccessful or if the current complaint was a significant change from the resident's past experience of pain. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease in range of motion or withdrawal or resistance to care. Observe and report to the nurse any signs of non-verbal pain: changes in breathing, vocalizations (grunting, moans, yelling out); mood/behavior (changes, more irritable, restless, aggressive, squirmy); face (sad, crying, worried, clenched teeth, grimacing); body (tense, rigid, curled up, thrashing). Observe and report to nurse loss of appetite, refusal to eat or weight loss. Resident D's Medication Administration Record (MAR) for April 2021 and May 2021, documented the following: A fentanyl patch, 72-hour, 12 micrograms per hour (mcg/hr) and to change every three days, was ordered on 1/05/20 for chronic pain and discontinued on 4/10/21. It was administered on 4/02/21, 4/05/21, 4/08/21 and 04/10/21. An identical order for fentanyl patch, 72-hour, 12 mcg/hr, was ordered on 4/20/21. It was applied/changed on 4/21/21, 4/24/21, 4/27/21, and 4/30/21, 5/03/21, 5/06/21, 5/09/21,			

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	5/12/21, 5/15/21 and 5/18/21. There was no record the facility applied or changed a fentanyl patch between 4/10/21 and 4/20/21. Morphine sulfate (concentrate) solution, 20 milligrams/milliliter (mg/ml), indicated to give .25 ml by mouth at bedtime. It was ordered on 4/10/20, administered from 4/10/21 through 4/14/21, and discontinued on 4/14/21. An order for scheduled morphine (.25 ml of 20 mg/ml) was changed on 4/14/21 to twice a day and administered from 4/14/21 through 5/20/21. Morphine sulfate (concentrate solution) 20 mg/ml, indicated to give .25 ml by mouth every two hours as needed for pain. It was ordered on 1/10/19. It was not administered during April 2021. Prior to 5/20/21, it was administered only once in May 2021, on 05/06/21, for pain rated at 6 on a scale of 1 to 10. The April and May 2021 MARs also indicated Resident D had an order to give 650 mg of acetaminophen (Tylenol) every 6 hours as needed for mild pain or fever. It was not administered in April or May 2021. Diclofenac sodium cream 1% (Voltaren, nonsteroidal anti-inflammatory) was ordered on 4/24/21 to be applied every morning and at bedtime for pain and was applied 4/24/21 through 5/20/21 to her right front knee. Resident D's physician orders reflected her fentanyl patch was discontinued on 4/10/21 and reordered on 4/21/21. Resident D's Skin Observation Tool, dated 4/24/21, indicated she had a stage 2 pressure ulcer on the front of her left knee and a skin tear			

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	on her right ankle. Resident D's Weights and Vitals record, dated 5/20/21, documented she lost 5.8 pounds between 4/06/21 and 5/06/21, representing a 5.4 percent weight loss over one month. It also documented she lost 16.8 pounds between 11/03/20 to 05/06/21 for a 14.2 percent weight loss over 180 days. Morphine (AVINza, Duramorph) was reviewed on 5/25/21 from the Davis's Drug Guide website (https://www.drugguide.com/ddo/). The guide indicated the peak effect of morphine administered orally was achieved after 60 minutes, the half-life (time of a drug's active substance to reduce by half) was 2 to 4 hours, and the duration was 4 to 5 hours. During an interview, on 5/18/21 at 5:08 p.m., Licensed Practical Nurse (LPN) 14 indicated Resident D had a fentanyl patch (opioid pain medication) which was changed every three days. She also received scheduled morphine. She observed the resident had breakthrough pain. Sometimes she woke up with it and she had it at varying times of the day. There was no pattern. Because of her dementia, the resident could not say if she had pain or request pain medication. She got agitated and fidgety and said things like, "I'm ready to go home." She responded well to scheduled pain medication when she received it. She was not over sedated, and LPN 14 could tell the difference the medication made because she would not yell out and was calmer and nicer to staff. She did not straighten one knee and she held her knees tightly together. Once positioned with pillows she slept better. She also had behavior symptoms of yelling out, resisting care and negative verbalizations when she got tired, as			

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	the sun went down every evening, or around 7:00 p.m. During an interview, on 5/19/21 at 5:01 p.m., Qualified Medication Aide (QMA) 2 indicated Resident D would not let anyone touch her. If they touched her leg the resident yelled "Ow!" and then stopped. She randomly screamed out. One leg was contracted; she could not straighten it. She had scheduled morphine and could also get morphine as needed (PRN) every two hours. QMA 2 indicated she thought her yelling out was a behavior symptom of resisting care and not related to pain. She screamed out when the doctor tried to examine her. She did not receive PRN morphine prior to receiving care by the CNAs. The resident barely ate. During an observation, on 5/19/21 at 5:10 p.m., the resident was heard yelling from the common area, more than two bedrooms away. Upon entering the room, the resident was in a wheelchair, dressed in clean clothes and had wet hair. CNA 15 was kneeling in front of the resident saying, "let me see your foot." CNA 16 was standing behind CNA 15. The resident was yelling out, "Ow! It Hurts! I want to go home! No one likes me!" She grimaced, clenched her eyes shut, and tightened her hands and shoulders. CNA 15 very lightly touched the top of the resident's knee, and the resident yelled out and indicated, "I don't like this." CNA 15 indicated the resident did this (yelled out) if she just touched her. The CNAs escorted the resident to the dining room in her wheelchair. She continued to say she did not like this and mumbled other indiscernible things. During an interview, on 5/19/21 at 5:20 p.m., CNA 16 indicated they had just given the resident a shower. CNA 15 and CNA 16 indicated they did			

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	155846	A. BUILDING 00 B. WING	05/20/2021

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	not know whether she was pre-medicated before receiving the shower. The two CNAs indicated the resident yelled out throughout the care they provided. During an interview, on 5/19/21 at 5:10 p.m., LPN 14 indicated she thought Resident D's crying out was more of a behavior symptom because she cried out with any/all care. She did not know if pain or behavior symptoms were discussed with the resident's doctor. When asked if the CNAs coordinated pain medication before providing care, the LPN indicated the CNAs asked her to assess the resident if they thought she was in pain. They did not ask for PRN medication with care because the resident always cried out. During an interview, on 5/19/21 at 5:20 p.m., CNA 15 indicated when they positioned Resident D in bed, she grabbed the CNA so tightly she left marks in the CNAs arms. The CNA demonstrated two red marks on the inside of one arm. CNA 15 indicated the resident verbalized she was in pain. The CNA said: "She's in pain." The CNA indicated there were four wedges on the sides of the bed: two on each side at the foot of the bed, and two on each side at the top of the bed. When the CNA positioned the resident in bed, she placed her on her left side, facing the wall. The resident gripped the wedge at the top of the bed on the left so tightly, she pulled the foam out of the cushion. The resident would not lay on her back. She did not straighten out her leg. She crossed her legs so tightly, she had red marks on her legs. CNA 15 put a pillow between her knees, but the resident pulled it out. Observation at this time, confirmed the cushion/wedge at the top left side of the bed was torn and a long piece of foam was on a chair across the room. There was only one			

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	pillow in the room, at the top of the bed. During an interview, on 5/20/21 at 11:21 a.m., NP 17 indicated Resident D had some contractures due to osteoarthritis (degenerative joint disease with common symptoms of joint pain and stiffness). The resident could not put her right knee into extension. Usually, hospice managed the pain medicine. The facility's physician saw the resident on 4/10/21. Staff said her pain seemed under treated. She had orders for PRN morphine, but she could not request it because of severe dementia. The physician added scheduled morphine and discontinued the fentanyl patch because she would have scheduled morphine. NP 17 saw the resident on 4/10/21 and 4/12/21 to make sure she was tolerating morphine okay. The resident wrenched when she tried to do anything with her right knee. There was no reported injury. The NP believed the pain was due to arthritic changes. She did not know if the resident could be seen by therapy because the resident was on hospice services. Perhaps therapy could recommend devices to help with positioning for comfort measures. None of the staff had mentioned reddened skin areas. She had not done an in-depth skin evaluation. No statements about behavior symptoms had been reported to the NP by staff, and she had not observed them. Had it been reported to her, she would normally look for acute causes for delirium (e.g., a urinary tract infection or medication change). If it was not medical, she would get a psychiatric consult. The resident had not had a recent psychiatric evaluation and was not receiving psychotropic medication. During an interview, on 5/20/21 at 12:20 p.m., the Therapy Director indicated no one had contacted him about Resident D's possible pain			

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	or contracture. Grabbing onto the side cushion so tightly she removed the foam, would definitely indicate pain. There was a possible mechanism for the facility's therapy department to work with the hospice residents and/or hospice may have their own therapist. With a referral, they could evaluate the resident to recommend positioning devices for comfort. During an interview, on 5/20/21 at 1:03 p.m., Resident D's hospice nurse indicated the resident could still walk a little bit when she was admitted to hospice but could not now. She had new, increased pain. The hospice service's Medical Director typically managed pain. They (the facility) discontinued her fentanyl patch and put her on scheduled morphine, twice a day but morphine was short acting. When the hospice nurse saw the resident a week later, she restarted her fentanyl patch because the resident was in excruciating pain. She kept her on her liquid, scheduled morphine. She was doing great on the fentanyl patch and had zero pain, even with care or movement. It had not been reported to her the resident was currently crying out during care. They had PRN morphine they could give her. According to the facility records, the last time the facility gave her the PRN morphine prior to today was on 5/06/21. Regarding her yelling out, even though the resident had dementia, they could not say her calling out was not related to pain. The hospice nurse wished the facility used the PRN more, because it helped them calculate the scheduled medication needs. When they saw how much PRN medication was administered in a 24-hour period they could assess her breakthrough pain and adjust her scheduled medications. For example, they could increase her fentanyl patch from 12 micrograms (mcg) an hour to 25 mcg an hour. No one had			

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	communicated issues with positioning. Therapy could evaluate her for comfort and positioning related to her right knee, even though the resident was receiving hospice services. She saw the resident "be nasty" to staff and other residents at times, but she was easily redirected. No one had reported sundowning, depression or behavior symptoms. No psychiatric evaluation had been ordered. Had they known, they could order lorazepam (anti-anxiety) or try Zoloft (antidepressant). During an interview, on 5/20/21 at 2:25 p.m., LPN 5 indicated Resident D had some redness on her ankle where she tightly crossed her legs in bed. When she applied cream to her knee, the resident screamed: "get away!" After she received her morning medications, including her scheduled morphine, she was nice. A current facility policy, titled "Pain - Clinical Protocol," dated June 2013 and provided by the Executive Director on 8/20/21, indicated "...2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. 3. The staff and physician will identify the nature (characteristics such as location, intensity, frequency, pattern, etc.) and severity of pain...The staff will observe the resident (during rest and movement) for evidence of pain; for example, grimacing while being repositioned or having a wound dressing changed...The staff will discuss significant changes in levels of comfort with the attending physician who will consider adjusting interventions accordingly. This may include non-pharmacological measures and adjustments of regular and PRN analgesic doses to find the			

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	best combination of effectiveness and tolerable side effects...If the resident's pain is complex or not responding to standard interventions, the attending physician may consider a psychiatric evaluation or referral to a pain clinic or specialist." This Federal Tag relates to complaints IN00351036 and IN00350758. 3.1-37(a)			
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.			

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	§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview and record review, the facility failed to post the nurse staffing data on a daily basis in 3 of 5 resident-occupied cottages (Cottages 1, 2 and 3). Findings include: 1. During an observation, on 5/16/21 at 4:59 p.m., in Cottage 2, the Daily Staffing Sheet was dated 5/14/21. During an interview, at that time, Licensed Practical Nurse (LPN) 5 indicated there was not a Daily Staffing Sheet for 5/15/21 or 5/16/21 posted in the cottage. 2. During an observation, on 5/16/21 at 5:04 p.m., in Cottage 3, the Daily Staffing Sheet was dated 5/14/21. The weekend Nurse Manager indicated there was not a Daily Staffing Sheet for 5/15/21 or 5/16/21 posted behind the one dated 5/14/21 or elsewhere in the cottage. 3. During an observation, on 5/16/21 at 6:02 p.m., in Cottage 1, the Daily Staffing Sheet was dated 5/14/21. The weekend Nurse Manager indicated there was not a Daily Staffing Sheet for 5/15/21 or 5/16/21 posted in the cottage. During an interview, on 5/16/21 at 5:04 p.m., the	F 0732	**F 732What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**The nurse staffing data was immediately posted in Cottages 1, 2 and 3.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.All residents have the potential to be affected.What measures will be put into place and what systemic changes will be made to ensure that the Deficient practice does not recur;Educated the staffing coordinator on ensuring the daily staffing data is posted in all 5 Cottages.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. SDC/designee will audit each Cottage 5 days a week x 2months, then 4 days a week x 2 months, then 3 days a week for	06/19/2021

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	weekend Nurse Manager indicated it was the responsibility of the weekend Nurse Manager, the Assistant Director of Nurses and the Scheduler to post the daily nurse staffing information in the five resident-occupied cottages. During an interview, on 5/16/21 at 6:10 p.m., the Executive Director (ED) indicated each of the resident-occupied cottages should have the staffing information for the current date. They checked behind the three postings dated 5/14/21 and confirmed there were no more current postings behind them. A current facility policy, titled "Posting Household Staffing Form," dated 2016 and provided by the ED on 5/20/21 at 3:30 p.m., reflected the following "...Policy: The team member will ensure that the number of registered nurses, licensed practical nurses and Shahbazim [certified nurse aides] scheduled for each day is posted at the entrance to the community. Procedure: 1. At the end of each shift the director of nursing or designee will calculate the number of full time equivalent (FTE) for the following types of nursing team members that provided direct care to elders on that shift. A. Registered Nurses, B. Licensed Practical Nurses, ac. Shahbazim. 2. The calculated FTE will be recorded on daily nurse staffing form required by the Federal government...4. The form will be posted at the main entrances to the community and be accessible to elders [residents], family members and others in the public...." This Federal tag relates to Complaint IN00349905.		2 months. The results of the audit will be reviewed at the monthly quality assurance meeting. The QAPI program will review, update, and make changes as needed for sustaining substantial Compliance Date: June 19, 2021	

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	3.1-17(a)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure food was served in accordance with professional standards for food safety when the facility did not use a three-step process when manually washing dishware in the kitchen of 1 of 5 resident-occupied cottages. (Cottage 5). Finding includes: During an observation and interview in Cottage 5, on 5/16/21 at 5:35 p.m., Certified Nurse Aide (CNA) 9 was hand-washing the residents' dishes	F 0812	**F 812** **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 all food is prepared and served in accordance with professional standards for food service safety. No elder was identified to be affected by the	06/19/2021

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	(dinner plates, drinking glasses and utensils). She indicated she was washing them with Dawn dish soap. One sink was filled with soapy water and the second, nearby sink was empty. She was rinsing the dishes over the second, empty sink and then putting the dishes on a drying rack. She indicated sometimes she hand-washed the dishes, and sometimes she put them in the dishwasher, but offered no explanation for why. She indicated she was not using a sanitizer solution and had not taken the temperature of the water. CNA 10 was sitting at the nearby common dining table. CNA 10 observed CNA 9 washing the dishes. CNA 10 indicated she also occasionally hand-washed the residents' dishes. She usually used Dawn soap and "sanitabs" (sanitizing tablets) as follows: In sink one, she put Dawn detergent and sometimes added bleach. In sink 2 she put sanitabs. She washed the dishes in the Dawn soap, dipped them in the sink containing the sanitizer, rinsed them over the sink with sanitizer, and then placed them on the rack to dry. CNA 10 indicated the dishwasher was broken for a couple of months, and they had to hand-wash dishes. During an interview, on 5/18/21 at 5:26 p.m., the Registered Dietician (RD) indicated staff should not hand wash dishes in the sinks because each cottage had a dishwasher. All of the dishwashers functioned. There was a time when one or more of the dishwashers were not working, so they set up as a three-sink compartment system with a gray tub. The method for manual dishwashing was posted in Cottage 1. A current facility document, titled "Manual Dishwashing Procedure," undated and provided by the RD on 5/19/21 8:45 a.m., indicated "...Sort. Scrape. Wash with a good detergent in hot water, minimum 100 degrees Fahrenheit (F).		alleged deficient practice. Staff instructed to use the dish washer to wash dishes. **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.** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the Deficient practice does not recur;** Staff will be educated on the handwashing dishes policy and procedure. All dish washers are working. **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.** This deficient finding will be monitored by the dietitian through observation, and audit tool. A monitoring tool will be utilized 3 times a week x 4 weeks, then weekly 4 weeks, and then monthly x 4 months. The results will be reviewed at the monthly QAPI meeting, any concerns will have	

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	Rinse in clean water to remove detergent. Sanitize in hot water 170 F for at least 30 seconds or chemical sanitizer at 75 F for at least 1 minute (3 types): 1. Chlorine - at least 50 parts per million (ppm). 2. Iodine - at least 12.5 ppm. 3. Quaternary Ammonium, 3 to 6 tablets, 200 ppm to 400 ppm. Air Dry...." 3.1-21(i)(3)		been addressed upon discovery. /b> ="" span="">	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control 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:			

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	(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin 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			

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	its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program when 1 randomly observed Certified Nurse Aide (CNA 10) did not wear source control (a face shield or face mask) while eating with 4 residents. (CNA 10) Finding includes: During an observation, on 5/16 at 5:35 at p.m., Certified Nurse Aide (CNA) 10 was sitting at the common dining table in Cottage 5 immediately across from one unidentified resident. Three other residents were also sitting at the table. CNA 9 was washing dishes at a kitchen sink nearby. Two other staff members and the weekend nurse manager were present in the cottage. CNA 10 was eating dinner with the residents. She was not wearing face protection (face shield or mask). Her face shield and mask were lying face down on the table beside her. She indicated she was told it was okay to remove her source control if she was eating with the residents. The resident across the table from her asked her about it, and she told the resident there was new guidance from the Centers for Disease Control and Prevention (CDC). On 5/18/21 at 12:50 p.m., the Medical Records nurse provided a list of the COVID-19 vaccination status of all residents in Cottage 5 and staff working the evening shift of Sunday 5/16/21. The undated list indicated two employees were not vaccinated, CNA 9 and CNA 19. Qualified Medication Aide 7 received her first vaccination dose but had not received her second.	F 0880	**F 880** **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 maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections **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.** All elders in Cottage 5 have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the Deficient practice does not recur;** The DON/designee will education the staff on social distancing, eating with the elders and wearing face mask, and on how and when to don and doff PPE with return demonstration. How the corrective actions will be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place	06/19/2021

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	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	During an interview, on 5/18/21 at 12:50 p.m., the Medical Records nurse indicated she shared responsibility for the facility's infection control with the Director of Nurses. She indicated the staff could not eat with residents and could not be without source control around the residents. During an interview, on 5/18/21 at 12:50 p.m., the Executive Director indicated staff members could not eat with residents. They could not remove their face masks or face shields around residents. The Indiana State Department of Health guidance, titled "Long-term Care Facilities Guidelines in Response to COVID-19 Vaccination," updated on 5/03/21, reflected "...Fully vaccinated HCP [health care providers] should continue to wear a face mask while indoors at work. However, fully vaccinated HCP could dine and socialize together in breakrooms without masks or physical distancing, so long as residents are not present. If any unvaccinated HCP are present, all HCP in the room should wear mask and physically distance...." This Federal Tag relates to complaint IN00349905. 3.1-18(b)		**span="">** ="" span="">** The DON/designee will monitor to ensure all staff are wearing the proper mask, using PPE correctly this be monitored through observation, and audit tools. The daily visual rounds will be done daily 7 days a week for 6 months.The results of the audit will be reviewed at the monthly quality assurance meeting. The QAPI program will review, update, and make changes to the DPOC as needed. **Date of Compliance: June 29, 2021**	