STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

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F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00369813. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00369813 - Substantiated. Federal/ State deficiencies related to the allegations are cited at F677, F758, and F880. Unrelated tags are cited. Survey dates:1/18 and 1/19/22 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 6 Medicaid: 72 Other: 12 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/25/22.	F 0000	The Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. The facility respectfully requests a desk review for this plan of correction.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).			

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	§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure the resident's family or responsible party was informed of a positive COVID-19 rapid antigen test for 3 of 6 residents reviewed for COVID-19. (Residents C, D, and E) Findings include: 1. The record for Resident C was reviewed on 1/18/22 at 2:30 p.m. The resident was admitted on 1/1/22. Diagnoses included, but were not limited to, fracture of the right femur, traumatic stress disorder, multiple sclerosis, COVID 19, weakness, and dementia with behaviors. The Admission Minimum Data Set (MDS) assessment, dated 1/8/22, indicated the resident was moderately impaired for cognition. In the last 7 days, the resident received antipsychotic and antidepressant medications. The Infection Control line surveillance list indicated the resident was tested for COVID-19 with a rapid antigen test on 1/13/22. The resident tested positive at that time. A PCR test was administered and sent to the laboratory to confirm the diagnosis of COVID-19. There was no documentation in Nursing Notes on	F 0580	1) Residents C, D, and E could not be identified due to resident confidentiality 2) An audit was completed of all covid positives from the last 30 days to ensure family and/or responsible party notification was completed 3) IDT team and licensed nurses were educated on facilities policy “Nursing Facility Plan“, with an emphasis on notifying families and/or responsible parties when a resident tests positive for covid-19. 4) DON or designee will review all covid positives in morning clinical meeting to ensure family notification has occurred and has been documented. This will be an ongoing facility practice. The DON/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.	02/12/2022

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1/13/22 indicating the resident's family and/or responsible party was made aware the resident tested positive for COVID-19 with a rapid antigen test.

Nurses' Notes, dated 1/17/22 at 10:59 p.m., indicated the resident's emergency contact was notified of the resident testing positive for COVID and the resident would be placed on another unit for isolation at this time.

Interview with the Director of Nursing on 1/19/22 at 10:30 a.m., indicated staff were to notify the resident's family of all positive COVID tests on the day the results were obtained. The resident was sent to the COVID-19 unit on 1/17/22 after confirmation of the PCR test, as she had no symptoms.

2. The record for Resident D was reviewed on 1/18/22 at 2:10 p.m. Diagnoses included, but were not limited to, cerebral palsy, epilepsy, aphasia, COVID-19, and traumatic brain injury.

The Quarterly Minimum Data Set (MDS) assessment, dated 11/29/21, indicated the resident had short and long term memory problems, and was severely impaired for decision making. The resident was an extensive assist with 1 person physical assist for eating.

The Infection Control line surveillance list indicated the resident was tested for COVID-19 with a rapid antigen test on 1/13/22. The resident tested positive at that time. A PCR test was administered and sent to the laboratory to confirm the diagnosis of COVID-19.

Physician's Orders, dated 1/17/22, indicated place the resident in droplet isolation

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	precautions due to being positive for COVID-19 effective 1/13/22. Nurses' Notes, dated 1/17/22 at 10:44 p.m., indicated the resident's responsible party was made aware of the resident being transferred to south unit to be in isolation for positive PCR test. There was no documentation the resident's family member was notified on 1/13/22 the day the resident tested positive for COVID-19 on the rapid antigen test. Interview with the Director of Nursing on 1/19/22 at 10:30 a.m., indicated staff were to notify the resident's family of all positive COVID tests on the day the results were obtained. The resident was sent to the COVID-19 unit on 1/17/22 after confirmation of the PCR test, as she had no symptoms. 3. The record for Resident E was reviewed on 1/18/22 at 1:46 p.m. Diagnoses included, but were not limited to, stroke, left leg below the knee amputation, diabetes type 2, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 12/6/21, indicated the resident was severely impaired for decision making. The resident was an extensive assist with a 1 person assist for eating. The Infection Control line surveillance list indicated the resident was tested for COVID-19 with a rapid antigen test on 1/13/22. The resident tested positive at that time. A PCR test was administered and sent to the laboratory to confirm the diagnosis of COVID-19.			

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	Nurses' Notes, dated 1/17/22 at 10:54 p.m., indicated the resident's responsible party was notified of the resident having to be transferred to another unit for isolation due to having a positive PCR test for COVID-19. Interview with the Director of Nursing on 1/19/22 at 10:30 a.m., indicated staff were to notify the resident's family of all positive COVID tests on the day the results were obtained. The resident was sent to the COVID-19 unit on 1/17/22 after confirmation of the PCR test, as she had no symptoms. 3.1-5(a)(1)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADLs) were provide assistance related to eating for 2 of 5 residents reviewed for activities of daily living. (Residents D and E) Findings include: 1. On 1/18/22 at 9:36 a.m., the breakfast trays were brought into the south unit (COVID-19 unit) after sitting outside of the COVID-19 unit doors since 9:10 a.m. There was 1 LPN and 1 CNA working on the unit. At 10:13 a.m., Resident D was observed in bed. The resident was in droplet contact isolation for	F 0677	1) Residents D and E could not be identified due to resident confidentiality 2) All other residents have the potential to be affected. Upon discovering that meals were late staff went to assure that all residents needing assistance to be fed were fed. 3) All nursing staff were educated on ensuring that residents that need assistance with feeding are fed in a timely manner at meals 4) ED, DON, or designee will observe 5 meals per week x 30 days to ensure residents needing	02/12/2022

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	COVID-19. CNA 1 indicated at that time, the resident needed to be fed. The CNA cleaned off 2 over bed tables and walked in the room and placed a table by bed 1 and the other table by bed 2. She indicated both residents in the room needed assistance with eating. She placed the breakfast tray for the resident on the over bed table. A call light was on for another resident, so the CNA left the room and answered the light. She returned at 10:14 a.m. and sat down to feed the resident, approximately 38 minutes after the trays were brought onto the unit. At 10:22 a.m., the CNA left the room and walked over to the medication cart to retrieve straws for the resident to drink the milk. She walked back into the room and continued to feed the resident. She finished feeding the resident at 10:33 a.m. The LPN did not help pass any of the breakfast trays or help feed the residents. On 1/18/22 at 1:20 p.m., the lunch trays were brought into the COVID 19 unit by CNA 1. At 2:01 p.m., the resident received her lunch, approximately 41 minutes after they had arrived to the unit. The LPN did not help pass any of the lunch trays or help feed the residents. The record for Resident D was reviewed on 1/18/22 at 2:10 p.m. Diagnoses included, but were not limited to, cerebral palsy, epilepsy, aphasia, COVID-19, and traumatic brain injury. The Quarterly Minimum Data Set (MDS) assessment, dated 11/29/21, indicated the resident had short and long term memory problems, and was severely impaired for		assistance are fed timely, then 3 meals per week x 30 days, then weekly x 4 months. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.	

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decision making. The resident was an extensive assist with 1 person physical assist for eating.

The Care Plan, revised on 3/31/21, indicated the resident required assistance with activities of daily living. The approaches were to observed and anticipate resident's needs. The resident required a one person assistance with eating.

Interview with CNA 1 on 1/18/22 at 1:10 p.m., indicated she was the only CNA on the unit working. There were 2 residents who required to be fed for all meals. She saved those residents for last due to having to pass the trays to all of the other residents.

Interview with the Director of Nursing on 1/19/22 at 10:30 a.m., indicated the LPN should have helped with the meal trays and feeding the residents.

2. On 1/18/22 at 9:36 a.m., the breakfast trays were brought into the south unit after sitting outside of the COVID 19 unit doors since 9:10 a.m. There was 1 LPN and 1 CNA working on the unit.

At 10:13 a.m., Resident E was observed in bed. The resident was in droplet contact isolation for COVID-19. CNA 1 indicated at that time, the resident needed to be fed. The CNA cleaned off 2 over bed tables and walked in the room and placed a table by bed 1 and the other table by bed 2. She indicated both residents in the room needed assistance with eating. She placed the breakfast tray for the resident in bed 1 on the over bed table. A call light was on for another resident, so the CNA left the room and answered the light. She returned at 10:14 a.m. and sat down to feed the resident in bed 1, while

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	Resident E was in bed 2 and had to wait. At 10:33 a.m., she finished feeding the resident in bed 1. She left the room to get a carton of milk for Resident E and more straws off of the medication cart. At that time, LPN 1 handed the CNA a bag of clothes for another resident in the next room, who was in need of assistance getting dressed as EMS was outside the room waiting to take the resident somewhere. CNA 1 finished getting the resident dressed at 10:41 a.m. She walked down the hallway to answer another call light at 10:42 a.m., meanwhile Resident E was waiting to be fed. At 10:45 a.m., Resident E was fed breakfast, approximately 1 hour and 6 minutes later after the trays were brought onto the unit. The LPN did not help pass any of the breakfast trays or help feed the resident. On 1/18/22 at 1:20 p.m., the lunch trays were brought into the COVID 19 unit by CNA 1. At 2:01 p.m., the Resident D received a lunch tray and the CNA sat down to feed her, while Resident E had to wait to be fed. Resident E was fed at 2:15 p.m., approximately 55 minutes after the trays arrived to the unit. The LPN did not help pass any of the lunch trays or help feed the resident. The record for Resident E was reviewed on 1/18/22 at 1:46 p.m. Diagnoses included, but were not limited to, stroke, left leg below the knee amputation, diabetes type 2, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 12/6/21, indicated the resident was severely impaired for decision making. The			

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	resident was an extensive assist with a 1 person assist for eating. The Care Plan, revised on 10/20/21, indicated the resident required assistance with activities of daily living related to stroke, bilateral leg amputations, cognitive status, and weakness. The approaches were to provide assistance as needed and observe and anticipate resident's needs. The resident required a one person assistance with eating Interview with CNA 1 on 1/18/22 at 1:10 p.m., indicated she was the only CNA on the unit working. There were 2 residents who required to be fed for all meals. She saved the resident for last due to having to pass the trays to all of the other residents. Interview with the Director of Nursing on 1/19/22 at 10:30 a.m., indicated the LPN should have helped with the meals and feed the resident. This Federal tag relates to Complaint IN00369813. 3.1-38(a)(2)(D)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and			

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	(iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on record review and interview, the	F 0758	1) Resident C could not be	02/12/2022

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	facility failed to ensure a resident was free from unnecessary psychotropic medication related to monitoring for side effects of antipsychotic medication, documentation of an Abnormal Involuntary Movement Scale (AIMS) assessment, and prn (as needed) anti-anxiety medication ordered longer than 14 days for 1 of 3 residents reviewed for unnecessary medications. (Resident C) Finding includes: The record for the resident was reviewed on 1/18/22 at 2:30 p.m. The resident was admitted on 1/1/22. Diagnoses included, but were not limited to, fracture of the right femur, traumatic stress disorder, multiple sclerosis, COVID 19, weakness, and dementia with behaviors. The Admission Minimum Data Set (MDS) assessment, dated 1/8/22, indicated the resident was moderately impaired for cognition. In the last 7 days, the resident received antipsychotic and antidepressant medications. The Care Plan, dated 1/12/22, indicated the resident received an antipsychotic medication of Ziprasidone for post traumatic stress disorder, depression, and dementia with behaviors. The approaches were to observe for side effects of antipsychotic medications such as dystonia, dry mouth, blurred vision, constipation, urinary retention, hypotension, sedation, drowsiness, increased falls, dizziness, tachycardia, bradycardia, irregular heart rate, tardive dyskinesia, seizures, photosensitivity, sore throat, pill rolling, anxiety, agitation, blurred vision, sweating, rashes, headache, weakness, hang over effects, nausea, depression, hallucinations, aggressive behavior, rigidity,		identified due to resident confidentiality 2) All residents on psychotropic medications have the potential to be affected. An audit was completed on all residents on psychotropic medications to ensure monitoring orders were in, AIMS assessments completed, and stop dates on all PRN psychotropic 3) IDT team and license nurses were educated on psychotropic medications with an emphasis on ensuring there are AIMS assessments completed on antipsychotics, side effect monitoring for psychotropics, and stop dates in place for all PRN psychotropics. 4) DON or designee will review order recap report in daily clinical meeting to ensure all new orders for psychotropics have side effect monitoring, antipsychotics have AIMS assessment completed, and PRN psychotropics have a stop date. This will be an ongoing facility practice. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.	

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	restlessness, pacing inability to sit still, and sleep disturbance. Physician's Orders, dated 1/1/22, indicated Lorazepam Concentrate (an anti-anxiety medication) 2 milligram/milliliter (mg/ml), give 0.5 ml via peg tube every 12 hours as needed for agitation and Ziprasidone HCl 80 mg, give 1 capsule via peg tube two times a day. There was no AIMS assessment completed. There was no documentation the staff were monitoring for side effects of the antipsychotic medication. Interview with the Director of Nursing on 1/19/22 at 12:30 p.m., indicated there was no documentation for monitoring for side effects of the antipsychotic medication, nor was there an AIMS assessment completed while the resident was receiving the antipsychotic medication. The prn Lorazepam should have been discontinued and/or evaluated if the resident needed to have the medication. This Federal tag relates to Complaint IN00369813. 3.1-48(a)(2) 3.1-48(a)(3)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods			

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	that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure the residents received their meals at the proper temperature related to hot and cold food and resident complaints for 2 of 2 meals observed. (Residents H, G, and L) This had the potential to affect 13 of 15 residents residing on the COVID-19 unit. Findings include: 1. On 1/18/22 at 9:10 a.m., the breakfast cart with 13 trays was observed in between the plastic wall barrier and the double doors leading into the COVID-19 unit. No staff could see the trays, as there were no windows on the double doors. There was 1 CNA and 1 LPN working on the COVID-19 unit for 15 residents. There was a beverage cart located in the hallway. There was 1 pitcher of orange juice, 1 pitcher of coffee, and a large metal pan on the bottom shelf with many cartons of milk. There was no ice on the cartons of milk or the orange juice. At 9:36 a.m., the breakfast cart with the meal trays was brought into the unit. At 9:46 a.m., there were still 12 breakfast trays left on the cart to be passed. The plates were covered with a dome lid and just the plate was under it. The breakfast consisted of scrambled eggs, a sausage patty, and a styrofoam bowl of hot rice cereal. At 9:45 a.m., the beverage cart remained the	F 0804	1) Residents H, G, and L could not be identified due to resident confidentiality 2) All residents have the potential to be affected. Residents were interviewed to identify concerns with food temperatures. Facility policy was revised to include not utilizing Styrofoam containers in isolation room. 3) Nursing and dietary staff were educated on ensuring food and beverages are served at proper temperatures 4) Dietary manager, ED, or designee will take temperatures at 5 meals per week x 30 days to ensure food and beverages are at the proper temperature, then 3 meals per week x 30 days, then weekly x 4 months. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.	02/12/2022

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	same, no ice on the orange juice or the cartons of milk. Each carton of milk was warm to touch as was the orange juice. There were 6 breakfast trays left on the cart and the plates were cold to touch as were the white styrofoam bowls of hot rice cereal. Interview with Resident H on 1/18/22 at 10:00 a.m., indicated his food was cold, including the hot cereal and eggs. Interview with Resident G at 10:05 a.m., indicated her food was cold. She did not eat the eggs or hot cereal. The last resident was served their food at 10:45 a.m., approximately 1 hour and 35 minutes after the trays were observed outside the COVID-19 unit. No staff offered to heat up any of the food. 2. On 1/18/22 at 1:20 p.m., the lunch trays were brought into the COVID-19 unit. The meals were now observed in white styrofoam "to go" containers. Interview with Resident L on 1/18/22 at 1:31 p.m., indicated the breakfast was very cold this morning. They were served cream of rice hot cereal, a sausage patty and scrambled eggs. The resident was inquiring when the lunch meal would be served. The last resident was served lunch at 2:15 p.m., approximately 55 minutes after the trays entered the unit. Interview with Dietary Food Manager on 1/19/22 at 9:20 a.m., indicated the south unit was served			

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	last every day for meals. She was unaware the milk and orange juice on the beverage carts were not on ice the previous day. 3.1-21(a)(2)			
F 0809 SS=E Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.			
	Based on record review, observation and interview, the facility failed to ensure meals were served on time according to the scheduled times for 3 of 3 meals observed on the COVID-19 unit. This had the potential to affect 13 of 15 residents residing on the unit. Findings include:	F 0809	1) Residents did not sustain harm from the deficient practice and did receive their meals. 2) All residents have the potential to be affected. Residents were interviewed to identify concerns related to meal timeliness. 3) Nursing and dietary staff	02/12/2022

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	1. On 1/18/22 at 9:10 a.m., the breakfast cart with 13 trays was observed in between the plastic wall barrier and the double doors leading into the COVID-19 unit. No staff could see the trays, as there were no windows on the double doors. At 9:36 a.m., the breakfast cart with the meal trays was brought into the unit. At 9:46 a.m., there were still 12 breakfast trays left on the cart to be passed. The meal times for breakfast indicated the South unit was to be served at 8:30 a.m., with the tray line starting at 8:00 a.m. On 1/19/22 at 9:15 a.m., the breakfast trays arrived to the South unit. 2. On 1/18/22 at 1:20 p.m., the lunch trays were brought into the COVID-19 unit. The meals were now observed in white styrofoam "to go" containers. Interview with Resident L on 1/18/22 at 1:31 p.m., indicated the resident was inquiring when the lunch meal would be served. The meal times for lunch indicated the South unit was to be served at 1:00 p.m., with the tray line starting at 12:30 p.m. Interview with Dietary Food Manager on 1/19/22 at 9:20 a.m., indicated the south unit was served last every day for meals. The previous day, they were short staffed and today the trays were late because there was only a cook for breakfast. She was unaware the lunch trays arrived to the unit the previous day for lunch at 1:20 p.m. The dietary staff were supposed to call down to the unit to let them know the trays were on their way.		were educated on ensuring meals are served timely per facilities scheduled meal times 4) ED, DON, or designee will observe 5 meals per week x 30 days to ensure meals are served on time, then 3 meals per week x 30 days, then weekly x 4 months. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.	

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	3.1-21(c)			
F 0880 SS=F 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: (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;			

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	(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 its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to staff not wearing	F 0880	**F 880** **Corrective actions accomplished for those residents found to be affected**	02/12/2022

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	PPE (personal protective equipment) inside TBP (Transmission Based Precautions) rooms, no signs on resident room doors indicating TBP or positive for COVID-19, no signs at the facility entrances indicating there were positive COVID-19 residents residing in the building, wearing gloves in the hallway, no hand hygiene before donning and after glove removal, transporting soiled PPE in the hallway, no visible signs of increased cleaning on high touched surfaces, not monitoring residents who were in TBP for COVID-19 and not monitoring, tracking and trending other infections on a monthly basis during random observations and for 5 of 5 residents reviewed for infection control. This had the potential to affect all 90 residents who resided in the facility and 15 of 15 residents who resided on the COVID-19 unit. (Residents D, E, F, M, K, C and B). Findings include: 1. On 1/18/22 at 9:10 a.m., the south unit was observed with the double doors closed. At that time, there were several stop signs on the doors indicating not to enter. The South unit was where the residents who were positive for COVID-19 were being housed. There were 15 positive residents residing on the unit. None of the resident room doors had information to indicate the residents were positive for COVID-19. There was no information on the doors to indicate what type of isolation the residents were in, or information on what kind of PPE to don before entering the rooms. Some of the rooms had PPE available by the room door, while others had none. Two hand sanitizing units on the wall, located in the main hall of the COVID-19 unit, were empty.		**by the alleged deficient practice:** The residents identified are confidential related to complaint investigation. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. The DON or designee will complete the following: ·Ensure the resident/residents affected/potential affected has been isolated in Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Ensure all staff are aware of who is on isolation and appropriate signage implemented Policy: Criteria for Covid-19 Requirements and Resident Placement Indiana Department of Health: COVID-19 Infection Control Guidance in Long-term Care Facilities · Staff involved will be educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator	

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	The current and updated 11/22/21 "COVID-19 Infection Control Guidance in Long-term Care Facilities" policy, indicated "Instructional signage: Maintain signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)." 2. During a random observation on 1/18/22 at 9:19 a.m., CNA 1 was observed walking out of a positive COVID-19 resident room. She stopped at the entrance of the door and doffed the isolation gown and gloves in the hallway and carried them in her hands to the soiled utility room. The soiled PPE was uncontained as she walked down the hallway. After disposing of the PPE, she performed hand hygiene by using hand sanitizer from a wall dispenser in the hallway. She proceeded to walk in and out of resident rooms on the COVID-19 unit without wearing the proper PPE. She spoke with all the residents and assisted them as needed. 3. During a random observation on 1/18/22 at 9:36 a.m., the breakfast trays were brought onto the unit by CNA 1. The CNA proceeded to pass all of the trays to 13 residents without donning an isolation gown and gloves before entering their rooms. All the residents were positive for COVID-19. 4. During a random observation on 1/18/22 at 10:13 a.m., CNA 1 entered Resident D and E's room without wearing an isolation gown or gloves. The residents were both positive for COVID-19. The CNA had Resident D's breakfast meal. She pulled up a chair and repositioned the resident in bed, then sat down to feed her.		devices, gloves, gown, and eye protection. Follow CDC and facility policy. Policy: USE OF PPE WHILE IN THE FACIITY Policy: Criteria for Covid-19 Requirements and Resident Placement CDC: PPE sequence / Job Aides Competency: AAPACN PPE Indiana Department of Health: COVID-19 Infection Control Guidance in Long-term Care Facilities · Staff involved will be educated, with return demonstration, for hand hygiene (hand washing and ABHS) and understand when to perform hand hygiene. Follow CDC guidance and facility policy. Ensure Hand Hygiene items, including soap and water or ABHS are available at all times. Policy: General Hand Hygiene Competency: AAPACN Hand Hygiene Competency Indiana Department of Health: COVID-19 Infection Control Guidance in Long-term Care Facilities · Staff involved will be educated or appropriate way to dispose of contaminated items with potentially infectious agents. Ensure the potentially infectious	

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	At 10:22 a.m., the CNA left the room and walked over to the medication cart to get a straw for the resident. She walked back to the resident's room and sat down, again with no gloves or gown on and resumed feeding the resident. At 10:33 a.m., the CNA picked up a carton of milk from the beverage cart and walked back into the room to feed Resident E. She forgot a straw and walked out of the room and over to the medication cart to get the straw. At that time, LPN 1 handed the CNA a bag of clothes for Resident F, who was in need of assistance to go out of the facility for an appointment. The CNA placed the straw on the cart and walked into Resident F's room without wearing an isolation gown or gloves. Resident F was in isolation for COVID-19. At 10:35 a.m., while in the room, she donned a pair of clean gloves and helped the resident get dressed. At 10:36 a.m., she walked out of the room with the soiled gloves on her hands. She opened the soiled utility room with her gloved hands and threw them away. She did not perform hand hygiene after the gloves were removed. She came back to the resident's room with an isolation gown and gloves in her hands. Outside of the room, she donned the isolation gown and gloves, without performing hand hygiene and walked back into the room to assist the resident with dressing. At 10:42 a.m., CNA 1 answered a call light. She did not don an isolation gown or gloves prior to entering the room. Both residents in the room were positive for COVID-19. At 10:45 a.m., CNA 1 entered Resident E's room to resume feeding her without donning an isolation gown or gloves.		agents are transported in biohazard containers and disposed of according to policy. Follow CDC and facility policy. Policy: Criteria for Covid 19 Requirements and Placement · All residents will have Infection control screening completed and assessed as outlined by CDC and facility policy for the potential presence of COVID-19. Ensure staff involved are educated on Infection prevention and screening of residents. Policy: Criteria for Covid-19 Requirements and Resident Placement Indiana Department of Health: COVID-19 Infection Control Guidance in Long-term Care Facilities · Ensure all staff are educated on Infection control Practices of Tracking, Trending and Surveillance for all infections. Ensure they are aware of who to report infections to, and in turn infections are investigated, tracked, trended, and has ongoing surveillance. The facility must follow their Infection Control Plan. Policy: Infection Prevention Program · Ensure staff are educated on the correct products and use	

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	The current and updated 11/22/21 "COVID-19 Infection Control Guidance in Long-term Care Facilities" policy, indicated "COVID-19 Positive (Red Zone): These are residents who are confirmed COVID-19 positive and who, based on CDC criteria, still warrant standard contact droplet TBPs. · HCP will wear single gown with each resident, glove, N95 respirator masks mask and eye protection (face shield/or goggles that covers top, bottom, sides of the eye, with no gaps). Gowns and gloves should be changed after every resident encounter followed by hand hygiene: o Masks and eye protection may be used for the entire shift if not wet or visibly soiled. o Residents should be wearing masks when within 6 feet of the HCP unless medically contraindicated. o Gowns and gloves should be changed after every resident encounter followed by hand hygiene. o It is expected that facilities will follow conventional use (new gown for every encounter) unless absolutely necessary to do gown conservation. HCP should batch tasks (medication and food delivery, cleaning, vital checks) to maximize single gown use. o In areas of substantial to high transmission in which HCP are using eye protection for all patient encounters, extended use of eye protection may be considered as a conventional capacity strategy." 5. On 1/18/22 at 1:04 p.m., the COVID-19 unit was observed from just inside the unit entrance door. At that time, Resident M was observed reclined in a geri chair in the hallway across from the nurses' station. The resident was		for cleaning and disinfecting in the facility and facility equipment. Policy: Criteria for Covid 19 Requirements and Placement Indiana Department of Health: COVID-19 Infection Control Guidance in Long-term Care Facilities · Ensure housekeeping staff are educated on proper cleaning of resident rooms and proper placement and storage of housekeeping carts. Policy: Criteria for Covid 19 Requirements and Placement Indiana Department of Health: COVID-19 Infection Control Guidance in Long-term Care Facilities **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified	

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	observed removing his incontinent brief. CNA 1 and LPN 1 were observed standing over the resident trying to prevent the resident from removing the brief. The 2 staff members were observed touching the resident without wearing gloves or gowns. After the surveyor walked down the hallway on the COVID-19 unit, both LPN 1 and CNA 1 stopped what they were doing and donned isolation gowns and gloves, however, no hand hygiene was performed by either one. LPN 1 pushed the resident into his room to change his clothes and brief. The CNA followed the LPN to help. At 1:15 p.m., LPN 1 pushed the resident back over by the nurses' station. CNA 1 came out of the room as well and removed her gown and gloves and carried them uncontained down the hallway to the soiled utility room. The current and updated 11/22/21 "COVID-19 Infection Control Guidance in Long-term Care Facilities" policy, indicated "Hand hygiene [use of alcohol-based hand rub (ABHR) is preferred]: · Adherence to strict hand hygiene must continue for all, particularly HCP, including when entering the facility and before and after resident care. ABHR >60% are preferred unless hands are visibly soiled or when handwashing is advocated by CDC guidance. · ABHR > 60% should be readily available in resident rooms (ideally both inside and outside of the room) and in other resident and common areas) e.g., dining hall, therapy gym, medication rooms)." 6. During a random observation on 1/18/22 at 1:20 p.m., the lunch trays arrived to the COVID-19 unit. CNA 1 was observed to don an isolation gown and clean gloves in the hallway before entering a resident room to give them their lunch. The CNA did not perform hand		that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion. To ensure Infection Control Practices are maintained, the following monitoring will be implemented. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. ·Ensure all staff are aware of who is on isolation and	

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	hygiene prior to donning the gloves. After giving the lunch meals to the residents, she left the room and removed the isolation gown at the entrance of the room door. She carried it uncontained through the hallway and threw it away in the soiled utility room. The CNA repeated this 2 more times before she was stopped. Interview with CNA 1 on 1/18/22 at 1:30 p.m., indicated she was not aware she should dispose of the soiled PPE inside the rooms. She indicated there was only a small trash can in each room and it was located by the bathroom and not near the room door. Interview with the Director of Nursing on 1/19/22 at 11:14 a.m., indicated staff have been educated on proper PPE and how to don and doff PPE. They have been educated on hand hygiene before and after glove use as well. 7. During a random observation on 1/18/22 at 1:58 p.m., CNA 3 entered the COVID-19 unit through the entrance door that led to the outside of the facility wearing a hat and coat. The CNA was not wearing any face mask or face shield at all. She then walked right by Resident M who was seated by the nurses' station, also not wearing a mask. The current and updated 11/22/21 "COVID-19 Infection Control Guidance in Long-term Care Facilities" policy indicated "Masks (covering mouth and nose) and Eye Protection: · Direct and indirect care HCP should wear a medical procedure mask for the duration of their shifts. N95 respirator mask should be worn in COVID-19 units and with any resident who is symptomatic or in TBP (red or yellow zone)		appropriate signage implemented and PPE is available for each room · Ensure staff appropriately don and doff PPE · Ensure staff perform hand hygiene before donning and after doffing PPE · Ensure staff appropriately dispose of contaminated items with potentially infectious agents (PPE) in a trash can near the door before exiting a resident's room. · Ensure residents covid positive residents have Infection control screening completed and assessed (Respiratory / Covid symptom evaluation UDA) · Ensure the Infection Preventionist is tracking / trending with ongoing surveillance for all infections. · Ensure staff, including housekeeping, are performing high touch cleaning throughout the shift. 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified in B1 as above. This will	

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	awaiting testing." 8. During random observations on the COVID-19 unit on 1/18/22 from 9:10 a.m., to 11:00 a.m., and 1:04 p.m., to 3:00 p.m., there was no staff observed cleaning the high touched surfaces such as hand rails, door knobs, and over bed tables. Interview with LPN 1 and CNA 1 on 1/18/22 at 3:00 p.m., indicated neither one of them did any cleaning of the high touch areas during their shift. LPN 1 indicated there was not enough time to do that and she was not sure when the last time the unit had been cleaned. Interview with CNA 2 on 1/19/22 at 9:10 a.m., indicated the midnight shift was supposed to clean the unit and was unsure if it had been done. Interview with the Housekeeping and Laundry Interim Supervisor on 1/19/22 at 1:25 p.m., indicated she was unaware she could go into the COVID-19 unit and clean the high touch areas at least 3 times a shift. She thought that once a person entered the COVID-19 unit you could not come off of it. Spray bottles of disinfectant were available and given to LPN 1 to clean high touched surfaces and objects. She would expect the high touch areas to be cleaned at least two to three times a shift. The current and updated 11/22/21 "COVID-19 Infection Control Guidance in Long-term Care Facilities" policy indicated "Cleaning and disinfecting: Perform frequent cleaning and disinfection of high touched surfaces in the facility with approved EPA disinfectants. Assure use of manufacture guidance for disinfection and perform this often, and in designated visitation		occur for 6 weeks and until compliance is maintained. ·Ensure all staff are aware of who is on isolation and appropriate signage implemented · Ensure staff appropriately don and doff PPE · Ensure staff perform hand hygiene before donning and after doffing PPE · Ensure staff appropriately dispose of contaminated items with potentially infectious agents (PPE) in a trash can near the door before exiting a resident's room. · Ensure residents covid positive residents have Infection control screening completed and assessed (Respiratory / Covid symptom evaluation UDA) · Ensure the Infection Preventionist is tracking / trending with ongoing surveillance for all infections. · Ensure staff, including housekeeping, are performing high touch cleaning throughout the shift. **Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI	

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	areas after each visit. · Use approved cleaning agents from: EPA List N: Disinfectants for Coronavirus (COVID-19) · Contact Time- EVS and HCP should know wet to dry times for proper disinfection." 9. On 1/19/22 at 12:14 p.m., CNA 2 was observed seated in a chair in the hallway next to the nurses' station in the COVID-19 unit. The CNA's N95 mask was resting on top of his forehead. A resident was sleeping in a geri-recliner across from the CNA and his mask was not in use. Interview with the CNA at that time, indicated he couldn't breathe and he had to take his mask off. Interview with the Infection Preventionist on 1/19/22 at 1:00 p.m., indicated the CNA should have had his mask on. She also indicated if he was having issues breathing, he should have gone to the break room on the unit to remove his mask. 10. The record for Resident K was reviewed on 1/18/22 at 3:25 p.m. The resident was admitted on 1/12/22. Physician's Orders, dated 1/12/22, indicated respiratory/COVID screener: Any of the following signs and symptoms noted: fever /chills, shortness of breath, body aches, cough-dry/productive, diarrhea, nausea/vomiting, congestion, headache, loss of appetite/smell/taste, fatigue, and sore throat. The resident was unvaccinated and was to be in TBP for 14 days.		program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	

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	The Medication Administration Record (MAR) for 1/2022, indicated the resident was monitored every shift for temperature, respirations, signs and symptoms of COVID-19, and oxygen saturations. There was no documentation a full set of vital signs including pulse and blood pressure was documented every shift while the resident was in quarantine and on TBP. Interview with the Director of Nursing on 1/19/22 at 11:14 a.m., indicated a full set of vital signs was to be completed while residents were in the yellow zone. 11. The record for Resident D was reviewed on 1/18/22 at 2:10 p.m. Diagnoses included, but were not limited to, cerebral palsy, epilepsy, aphasia, COVID-19, and traumatic brain injury. The Quarterly Minimum Data Set (MDS) assessment, dated 11/29/21, indicated the resident had short and long term memory problems, and was severely impaired for decision making. The resident was an extensive assist with 1 person physical assist for eating. The Infection Control line surveillance list indicated the resident was tested for COVID-19 with a rapid antigen test on 1/13/22. The resident tested positive at that time. A PCR test was administered and sent to the laboratory to confirm the diagnosis of COVID-19. Physician's Orders, dated 1/17/22, indicated place resident in droplet isolation precautions due to being positive for COVID-19 effective 1/13/22. Physician's Orders, dated 9/28/21, indicated respiratory/COVID screener: Any of the			

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	following signs and symptoms noted: fever /chills, shortness of breath, body aches, cough- dry/productive, diarrhea, nausea/vomiting, congestion, headache, loss of appetite/smell/taste, fatigue, and sore throat. The Medication Administration Record (MAR) for 1/2022, indicated the resident was monitored every shift for temperature, respirations, signs and symptoms of COVID-19, and oxygen saturations. There was no documentation a full set of vital signs including pulse and blood pressure was documented every shift while the resident was in isolation for COVID-19. Interview with the Director of Nursing on 1/19/22 at 10:30 a.m., indicated there was a COVID-19 monitoring assessment specifically for COVID-19 only residents that should have been ordered for all the residents who tested positive. The assessment would include a full set of vital signs to be done every shift. 12. The record for Resident E was reviewed on 1/18/22 at 1:46 p.m. Diagnoses included, but were not limited to, stroke, left leg below the knee amputation, diabetes type 2, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 12/6/21, indicated the resident was severely impaired for decision making. The resident was an extensive assist with a 1 person assist for eating. The Infection Control line surveillance list indicated the resident was tested for COVID-19 with a rapid antigen test on 1/13/22. The resident tested positive at that time. A PCR test was administered and sent to the laboratory to confirm the diagnosis of COVID-19.			

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Physician's Orders, dated 9/28/21, indicated screen for signs and symptoms of COVID-19. Any of the following signs and symptoms noted: fever/chills, shortness of breath, body aches, cough- dry/productive, diarrhea, nausea/vomiting, congestion, headache, loss of appetite/smell/taste, fatigue, sore throat. If any signs and symptoms noted, complete the COVID-19 Symptoms Evaluation.

There were no Physician's Orders for the resident to be placed in droplet isolation for COVID-19.

The Medication Administration Record (MAR) for 1/2022, indicated the resident was monitored every shift for temperature, respirations, signs and symptoms of COVID-19, and oxygen saturations. There was no documentation a full set of vital signs including pulse and blood pressure was documented every shift while the resident was in isolation for COVID-19.

The last recorded blood pressure was documented on 6/8/21 and there was no pulse documented in the vital section in the clinical record.

Interview with the Director of Nursing on 1/19/22 at 10:30 a.m., indicated there was a COVID-19 monitoring assessment specifically for COVID-19 only residents that should have been ordered for all the residents who tested positive. The assessment would include a full set of vital signs to be done every shift.

13. The record for the resident was reviewed on 1/18/22 at 2:30 p.m. The resident was admitted on 1/1/22. Diagnoses included, but were not

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	limited to, fracture of the right femur, traumatic stress disorder, multiple sclerosis, COVID 19, weakness, and dementia with behaviors. The Admission Minimum Data Set (MDS) assessment, dated 1/8/22, indicated the resident was moderately impaired for cognition. In the last 7 days, the resident received antipsychotic and antidepressant medications. The Infection Control line surveillance list indicated the resident was tested for COVID-19 with a rapid antigen test on 1/13/22. The resident tested positive at that time. A PCR test was administered and sent to the laboratory to confirm the diagnosis of COVID-19. There were no Physician's Orders for monitoring signs and symptoms of COVID-19. There were orders for the resident to be placed in droplet isolation after testing positive for COVID-19. There were no orders to perform prn COVID-19 testing. The last documented oxygen saturation, temperature, blood pressure, pulse and respirations was documented on 1/1/22. Interview with LPN 1 on 1/18/22 at 2:50 p.m., indicated there was usually an assessment open for the residents to be monitored for signs and symptoms of COVID. The Director of Nursing had not entered the information into the computer, so there was no place to document an assessment. The Indiana Department of Health current and updated 1/4/22 "Long-term Care COVID-19 Clinical Guidance" policy indicated, "Screen all residents daily for fever and for COVID-19			

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	symptoms. Ideally, include an assessment of oxygen saturation via pulse oximeter. · Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximeter, and respiratory exam, to at least three times daily to identify and quickly manage serious infection." 14. The Infection Control binder was reviewed on 1/19/22 at 11:54 a.m. For the months of November and December 2021, there was no documentation on the monthly log. There was also no mapping data and information related to the monthly infection rate. There was no way to determine how patterns and trends were being monitored. When the binder was provided by the Director of Nursing on 1/19/22 at 9:15 a.m., she indicated she was behind in completing the monthly infection data for November and December 2021. 15. Resident B's record was reviewed on 1/18/22 at 11:15 a.m. Diagnoses included, but were not limited to, hypertension and bipolar disorder. He currently resided on the COVID-19 positive unit. The Quarterly Minimum Data Set (MDS) assessment, dated 10/25/21, indicated the resident was moderately cognitively impaired. The resident required extensive assist of 1 for bathing, dressing and personal hygiene. On 1/13/22, the facility collected a PCR COVID-19 Test for Resident B. On 1/14/22, the test result was reported as positive for COVID-19 and he was placed in transmission based precautions on the COVID unit.			

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	The current January 2022 Medication Administration Record (MAR) indicated that he was monitored every shift for general signs and symptoms of COVID-19. There was no indication in the MAR or the Nursing Progress Notes that full vital signs, a respiratory evaluation, and oxygen saturation were being monitored every shift per guidelines. The Indiana Department of Health current and updated 1/4/22 "Long-term Care COVID-19 Clinical Guidance" policy indicated, "Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximeter. · Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximeter, and respiratory exam, to at least three times daily to identify and quickly manage serious infection." This Federal Tag relates to Complaint IN00369813. 3.1-18(b)			
F 9999 Bldg. 00	3.1-18 INFECTION CONTROL PROGRAM (b) The facility must establish an infection control program under which it does the following: (7) Reports communicable disease to public health authorities. This state rule was not met as evidenced by:	F 9999	1) 43 residents and 20 staff were identified as being affected by the deficient practice. 2) All residents and staff that test positive have the potential to be affected by the deficient practice. 3) The Divisional IP Nurse has reviewed the reporting process	02/12/2022

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	Based on record review and interview, the facility failed to establish an Infection Control program which included a system that reported communicable disease to public health authorities related to not reporting COVID-19 positive staff and resident cases to the Indiana Department of Health (IDOH) as required. This had the potential to affect all residents in the facility. Finding includes: Interview with the Director of Nursing (DON) on 1/19/22 at 1:15 p.m., indicated the facility's most recent COVID-19 outbreak started on 12/10/21. A total of 45 residents and 29 staff members had tested positive during the current outbreak. Review of the COVID-19 LTC (Long Term Care) Case and Death reports, dated 1/3-1/19/22, indicated the facility had 2 residents and 9 staff members who had tested positive in that time frame. Interview with the DON on 1/19/22 at 4:30 p.m., indicated she had been reporting the POC (point of care) test completion, but had fallen behind with reporting the positive only results to Redcap, and indicated the positive only cases should have been reported to Redcap within 24 hours of the positive result. The IDOH "LTC Facility COVID-19 Data Submission Guidelines", dated 12/22/20, indicated, ".... Importantly, the state requires that facilities report to the following systems, which are focused on patient-level testing information:		with the Executive Director to ensure the appropriate process is being followed based on the “infection Prevention Program” policy and procedure. 4) The Administrator/DON/Designee will keep a screen shot of each COVID 19 positive employee test reported to the Red Cap system as confirmation reporting was completed. This will continue for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, then randomly thereafter for further recommendations.	

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	- Long-term Care COVID-19 Reporting form (required for all SNF/NF [skilled care] and RCF/AL [Assisted Living]) - COVID-19 Point of Care (POC) Test Reporting form (Certified nursing homes [SNF/NFs] are exempt from this reporting beginning October 28, 2020 and should begin reporting point-of-care testing to NSHN directly; required for all RCF/AL [Assisted Living]) - Death Reporting Line for COVID-19-related deaths ...."			