

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2021
NAME OF PROVIDER OR SUPPLIER HOMESTEAD HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227		
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00345707, IN00345721, IN00346600, IN00346368, IN00347461, IN00347797 and a COVID-19 Focused Infection Control Survey.</p> <p>This visit resulted in a Partially Extended Survey - Substandard Quality of Care-Immediate Jeopardy.</p> <p>Complaint IN00345707 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00345721 - Substantiated. Federal/State deficiencies related to the allegation are cited at F694.</p> <p>Complaint IN00346600 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00346368 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00347461 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00347797 - Unsubstantiated due to lack of evidence.</p> <p>Survey Dates: February 15, 17, 18, and 19, 2021</p> <p>Facility Number: 012225 Provider Number: 155780 AIM Number: 200983560</p> <p>Census Bed Type: SNF/NF: 58 Total: 58</p> <p>Census Payor Type: Medicare: 3 Medicaid: 50 Other: 5</p>	F 0000	<p>The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Homestead Healthcare Center.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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F 0694 SS=J Bldg. 00	<p>Total: 58</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2 3.1.</p> <p>Quality Review completed on February 24, 2021.</p> <p>483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and interview, the facility failed to ensure an Intravenous (IV) Peripherally Inserted Central Catheter (PICC) site was assessed, maintained, and cared for; which resulted in hospitalization, diagnosis of sepsis, and death for 1 of 2 residents reviewed for IV PICC line (Resident B). In addition to the resident in immediate jeopardy, the facility failed to ensure a resident's Peripherally Inserted Central Catheter (PICC Line) site was monitored and recorded in the clinical record resulting the potential for more than minimal harm that is not immediate jeopardy for 1 of 3 residents reviewed for IV line care (Resident L). The immediate jeopardy began on 1/08/2021 when Resident B had a PICC line inserted and the facility failed to ensure PICC line care and monitoring were completed for 8 days, when the resident was found non-responsive on 1/16/2021, and sent to the hospital where the resident was diagnosed with sepsis from a PICC line infection and later died. The Executive</p>	F 0694	<p><i>The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Homestead Healthcare Center.</i></p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident A no longer resides at the facility. Identification of other residents</p>	03/21/2021

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	<p>Director and Director of Nursing were notified of the immediate jeopardy at 4:06 p.m. on 2/18/2021. The immediate jeopardy was removed on 2/19/2021, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with the potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>1. Resident B's closed clinical record was reviewed on 2/18/2021 at 10:04 a.m., Diagnoses included, but were not limit to, seizure disorder. Additional diagnosis of COVID-19 was added on 12/31/20, and Resident B was placed on droplet isolation.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 12/24/2020, indicated Resident B's cognitive status was moderately impaired. Resident B required extensive assist of one for bed mobility and transfers. Supervision was required for ambulation, eating, dressing, and personal hygiene.</p> <p>Laboratory data results dated, 1/7/2021 indicated, "hyponatremia" (low blood sodium). Resident B's physician indicated due to hyponatremia/dehydration and acute kidney injury with required fluid restrictions, a central IV catheter will be implemented with an order for normal saline solution 0.9% of 2 liters one time only.</p> <p>Medication Administration Records, dated 1/1/2021 through 1/31/2021, indicated an order dated 1/7/2021, for "Normal saline solution 0.9%, use 2 liter intravenously one time only for abnormal labs for 1 day. Run wide open times 2</p>			<p>having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>All residents with an Intravenous Access device placed have the potential to be affected. All residents residing in the facility that have an Intravenous Access device placed have had their site assessed for signs and symptoms of infection and documented appropriately. An audit has been conducted on residents with an Intravenous Access device to validate orders are in place for assessment, maintenance, and care.</p> <p>An audit was conducted on all residents residing in facility to identify all Intravenous Access Devices. Three residents identified and have had their site assessed and orders validated to ensure assessment, maintenance, and care is documented in the medical record. Plan of care updated accordingly.</p> <p>No other residents were found to have an Intravenous Access Device.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Measures put in place and systemic changes made to</p>	

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	<p>liters."</p> <p>A progress note, dated 1/7/2021 at 9:08 p.m., indicated Resident B had a PICC line inserted, as ordered by the Physician and saline was to be administered, due to dehydration. Reportedly he had not eaten or drank anything for 10 days.</p> <p>A progress note, dated 1/8/2021 4:03 p.m., indicated "Midline [PICC] intact to the Lt [left] upper arm with N/S [normal saline] infusing as ordered, transparent dressing intact no s/s [signs/symptoms] of infection at the site. Resident is alert/orient to self and others, appetite is poor, incontinent of urine and bm [bowel movement]. v/s wnL [vital signs within normal limits]."</p> <p>The clinical record lacked other progress notes regarding the assessment, care, and/or maintenance of the PICC line.</p> <p>The clinical record lacked a care plan to provide goals and interventions to care for the PICC line.</p> <p>The clinical record lacked Physician's orders that would have provided instructions regarding the care of and the procedures for the PICC line.</p> <p>The January 2021, Medication Administration Records and Treatment Administration Records lacked documentation of assessment, care, and/or maintenance of the PICC line.</p> <p>A Progress note, dated 1/16/2021 at 8:39 a.m., indicated Resident B was found to be non-responsive and was sent to the Emergency Room.</p> <p>Emergency Room notes, dated 1/16/2021 [no</p>		<p>ensure the alleged deficient practice does not recur:</p> <p>All licensed nurses have been educated on the facility's "Central Venous Access", and "Peripheral Venous Access" policies with emphasis on assessment, maintenance, and care.</p> <p>Skills validation has been completed with return demonstration on all licensed nurses for: Care of a Central Venous Catheter, Administration of Medication via an IV, and Administration of IV Fluids.</p> <p>All licensed nurses have been educated on following physician orders with emphasis on documentation and the order transcription process including but not limited to Intravenous Access Devices.</p> <p>Licensed nurses have been educated to notify the DON of any new order regarding Intravenous Access Devices 7 days a week.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>The DON or designee will validate that all residents with an Intravenous Access device have had their site assessed for signs and symptoms of infection and documented appropriately 5 times per week for 4 weeks, then 3</p>	

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	<p>time], indicated "...Severe sepsis/septic shock [life-threatening physical response to an infection] source included line related, due to the PICC line that reportedly was infected with purulent drainage [discharging pus]...Emergency Room Registered Nurse, reports patient arrived with left upper extremity midline IV access with heavily soiled dressing, unable to flush and purulent drainage."</p> <p>Hospital Notes, dated 1/17/2021 [no time], indicated "...blood cultures positive for staph aureus [bacterial infection] confirming the suspicion for (PICC) line sepsis."</p> <p>Hospital Notes, dated 2/1/2021 [no time], indicated Resident B "was critically sick." Due to "septic shock" related to PICC line infection. Resident's Mother was updated about patient's condition and told he would "probably not survive. Prognosis Poor, unlikely to survive hospitalization. Patient is in the process of dying. Patient made Do Not Resuscitate (DNR) at family request."</p> <p>Hospital notes, dated 2/2/21, indicated "Time of death 2/2/21 at 9:40 a.m."</p> <p>During interview, on 2/18/2020 at 12:10 p.m., Licensed Practical Nurse (LPN) 2, indicated she recalled Resident B having had a PICC line. LPN 2 did not recall having documented any care for the resident's PICC Line. The documentation of assessments of the PICC line should have been on the, "Medication Administration Record."</p> <p>During interview, on 2/18/2020 at 12:10 p.m., LPN 3, indicated she took care of Resident B during the time he had a PICC line. She did not</p>			times per week for 4 weeks, then monthly for 4 months.

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	<p>recall any treatments on the Medication Administration Record regarding the PICC line. LPN 3 did not recall having documented any assessment regarding Resident B's PICC line.</p> <p>During interview, on 2/18/2020 at 11:30 a.m., the Director of Nursing (DON), indicated all care, treatments, assessments of the PICC line should have been documented on the Medication Administration Record. The DON indicated the facility had no additional documentation and/or care plan for the assessment, care, and/or maintenance of Resident B's PICC line.</p> <p>On 2/18/2021 at 11:24 a.m., the Director of Nursing provided a policy titled Central Venous Access, dated February 2009, and indicated it was the current policy being used by the facility. A review of the policy indicated, "1. Site Care...8. Observe the insertion site for a. erythema, b. purulent drainage c. edema. [infection] ...15. Document the procedure, site appearance, and patient's tolerance of the procedure in nurse's notes. ... III. Flushing ...3. Flush catheter ..."</p> <p>2. Resident L's clinical record was reviewed on 2/18/21 at 2:00 p.m. Diagnosis included, but not limited to, anemia.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 2/2/21, indicated Resident L was cognitively intact and required assistance of one staff member for toileting, personal hygiene, and bathing.</p> <p>The Physician's order, dated 12/22/20 with no end date noted, indicated "...Mid/Central (PICC) [Peripherally Inserted Central Catheter] Line...monitor site...every shift..."</p>			

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	<p>Resident L's care plan, initiated on 2/11/21 and current through 5/3/21, indicated "...is at risk for infection due to midline/PICC...observe midline/PICC site for signs and symptoms of infection as ordered..."</p> <p>The Treatment Administration Record (TAR), dated February 1 through 28, 2021, indicated "...Mid/Central (PICC) Line...monitor site...every shift..." The February 2021 TAR record indicated 17 of 52 shifts lacked signatures which indicated the PICC Line site was monitored and the results recorded in the clinical record for the following dates and shifts:</p> <p>On 2/2/21 - night shift On 2/5/21 - evening shift On 2/6/21 - night shift On 2/7/21 - evening shift On 2/7/21 - night shift On 2/8/21 - day shift On 2/11/21 - evening shift On 2/11/21 - night shift On 2/12/21 - day shift On 2/12/21 - evening shift On 2/13/21 - day shift On 2/13/21 - night shift On 2/14/21 - evening shift On 2/15/21 - day shift On 2/15/21 - evening shift On 2/15/21 - night shift On 2/16/21 - evening shift</p> <p>During interview, on 2/18/21 at 3:00 p.m., RN (Registered Nurse) 4 indicated Resident L's PICC Line site was to be monitored on each shift as indicated by the Physician's orders. The TAR record lacked staff signatures which would have validated the site was monitored and recorded in</p>			

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	<p>the clinical record.</p> <p>On 2/18/21 at 4:00 p.m., the Director of Nursing provided a copy of the facility's Clinical Documentation Standards, dated 5/29/2019, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...a complete record contains an accurate and functional representation of actual experience of the resident and must contain enough information to show that the status of the individual resident is known...Basic Nursing Standards of Documentation: the primary purpose of the medical record is to provide continuity of care...clinical evidence of care and treatment records as evidence of care...document entries during the work shift and complete all entries before leaving the facility for that tour/shift...chart in "real time" when an event is occurring or shortly thereafter..."</p> <p>The immediate jeopardy, that began on 1/8/21 was removed on 2/19/21, when the facility identified and assessed all residents with Intravenous Access devices for signs and symptoms of infection and documented as indicated by facility policy. An audit had been conducted on all residents with Intravenous Access devices to validate orders were in place for assessment, maintenance, and care. All licensed nurses had been educated on the facility's Central Venous Access and Peripheral Venous Access policies with emphasis on assessment, maintenance, and care. Skills validation had been completed with return demonstration on all licensed nurses for: care of central venous catheter, administration of medication via an IV, and Administration of IV fluids. All licensed nurses had been educated on following physician orders with emphasis on</p>			

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F 0880 SS=E Bldg. 00	<p>documentation and the order transcription process including, but not limited to, Intravenous Access Devices. Noncompliance remained at the lower scope and severity of isolated, no harm, with potential for more than minimal harm that is not immediate jeopardy; because of the need for continued monitoring.</p> <p>This Federal tag relates to Complaint IN00345721.</p> <p>3.1-47(a)(2)</p> <p>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.</p> <p>§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:</p> <p>§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;</p>			

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	<p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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. <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p>			

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	<p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff removed their PPE (personal protective equipment) prior to exiting an isolation room for 2 of 4 residents in droplet isolation precautions, within the yellow zone (unknown COVID-19 status) (Residents Q and R) and the facility failed to ensure correct placement of disposal receptacles (trash cans) for used PPE was implemented for 4 of 14 residents in droplet isolation precautions, within the yellow zone (unknown COVID-19 status), who were reviewed for infection control precautions (Residents N, Q, R, and S).</p> <p>Findings include:</p> <p>1a. On 2/19/21 at 2:00 p.m., observed Resident Q's door to be opened. Observed a sign posted on Resident Q's door. The sign indicated, "Yellow zone, transmission-based precautions, contact droplet, PPE [personal protective equipment] required...N95 mask - approved KN95...face shield or goggles...single gown - with each encounter gowns must be single use per resident...gloves." At that same time, observed OT (Occupational Therapist) 5 inside Resident Q's room. OT 5 was wearing goggles, N95, gloves, and gown. OT 5 was observed walking across the room and stepped outside the Resident's room into the hall with full PPE on. During an interview at that time, OT 5 indicated prior to exiting the isolation room he was to remove and discard the gown and gloves into the trash can located inside the Resident's room. OT</p>	F 0880	<p>F 880</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The residents identified are confidential related to complaint investigation.</p> <p>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.</p> <p>The DON or designee will complete the following:</p> <ul style="list-style-type: none"> Ensure facility staff involved are educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. Follow CDC and facility policy. 	03/15/2021

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	<p>5 was then observed walking back into Resident Q's room; removed and disposed of the used gown and gloves into the trash can; and exited the Resident's room.</p> <p>The clinical record of Resident Q was reviewed at 2/19/21 at 2:35 p.m. Diagnosis included but not limited to, right and left below knee amputation and frostbite.</p> <p>Physician's orders, dated 2/8/21, indicated, "...place Resident in droplet plus isolation..."</p> <p>Resident Q's care plan, date initiated 2/8/21, revised on 2/19/21, and current through 5/9/21, indicated "...resident is on droplet isolation due to at risk for COVID-19 related to potential exposure with recent hospitalization/admission from community..."</p> <p>During interview, on 2/19/21 at 2:45 p.m., the Director of Nursing indicated Resident Q was placed in droplet isolation due to being admitted to the facility from the hospital. Staff were required to remove and dispose of the used PPE inside of the Resident's room prior to exiting the room. Currently, the census on yellow zone (unknown COVID-19 status) was 14.</p> <p>1b. On 2/19/21 at 2:00 p.m., observed Resident R's door to be opened. Observed a sign posted on Resident R's door. The sign indicated, "Yellow zone, transmission-based precautions, contact droplet, PPE [personal protective equipment] required...N95 mask - approved KN95...face shield or goggles...single gown - with each encounter gowns must be single use per resident...gloves." At that same time, observed OT (Occupational Therapist) 5 inside Resident R's room. OT 5 was wearing goggles,</p>			<p>Policy: USE OF PPE WHILE IN THE FACILITY CDC: PPE sequence</p> <p>· Ensure facility staff involved are educated on the CDC guidance for PPE - Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html ? CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-inlong-term-care-facilities.html</p> <p>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.</p> <p>The root cause was identified resulting in the facility's failure.</p> <p>Solutions were developed and systemic changes were identified that need to be taken to address</p>	

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	<p>N95, gloves, and gown. OT 5 was observed walking across the room and stepped outside the Resident's room into the hall with full PPE on. During an interview at that time, OT 5 indicated prior to exiting the isolation room he was to remove and discard the gown and gloves into the trash can located inside the Resident's room. OT 5 was then observed walking back into Resident R's room; removed and disposed of the used gown and gloves into the trash can; and exited the Resident's room.</p> <p>The clinical record of Resident R was reviewed at 2/19/21 at 2:35 p.m. Diagnosis included but not limited to, sepsis due to E. Coli (Escherichia Coli, bacteria infection); emphysema; acute bronchitis; and acute respiratory failure.</p> <p>Physician's orders, dated 2/11/21, indicated, "...place Resident in droplet plus isolation..."</p> <p>Resident R's care plan, date initiated 1/27/21, revised on 2/19/21, and current through 4/27/21, indicated "...resident is on droplet isolation due to at risk for COVID-19 related to potential exposure with recent hospitalization/admission from community..."</p> <p>During interview, on 2/19/21 at 2:45 p.m., the Director of Nursing indicated Resident R was placed in droplet isolation due to being admitted to the facility from the hospital. Staff were required to remove and dispose of the used PPE inside of the Resident's room prior to exiting the room. Currently, the census on yellow zone (unknown COVID-19 status) was 14.</p> <p>On 2/19/21 at 4:10 p.m., the facility's Corporate Nurse provided a copy of the facility's Use of PPE While In The Facility document, dated</p>			<p>the root cause.</p> <p>The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>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.</p> <p>To ensure Infection Control Practices are maintained, the following monitoring will be implemented.</p> <ol style="list-style-type: none"> 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. 2. The IP nurse/DON/Designee will complete daily visual rounds 	

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	<p>11/30/20, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...gowns must be disposed of when exiting the resident room..."</p> <p>On 2/19/21 at 3:00 p.m., a review of the CDC (Center for Disease Control and Infection Control) isolation guidelines, located at https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html, indicated, "...Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens."</p> <p>On 2/19/21 at 3:15 p.m., a review of the CDC (Center for Disease Control and Infection Control) isolation guidelines, located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html? CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html, indicated, "...Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room..."</p> <p>2a. During a facility tour on 2/19/21 at 1:50 p.m., observed Resident N's door to be closed. Observed a sign posted on Resident N's door. The sign indicated, "Yellow zone, transmission-based precautions, contact droplet, PPE [personal protective equipment] required...N95 mask - approved KN95...face shield or goggles...single gown - with each</p>			<p>throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified in B1 as above. This will occur for 6 weeks and until compliance is maintained.</p> <p>Quality Assurance and Performance Improvement (QAPI): The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.</p>

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	<p>encounter gowns must be single use per resident...gloves." While inside Resident N's room observed a small uncovered trash can that was lined with a clear plastic trash bag. The trash can was located across the room from the door near the windows and no trash was observed inside the trash can. No other trash cans were observed in Resident N's room or private adjoining restroom. During an interview at that time, Resident N indicated he had only one trash can in his room and staff discarded their PPE into that trash can.</p> <p>The clinical record of Resident N was reviewed on 2/19/21 at 2:30 p.m. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease; sepsis; and history of urinary tract infections.</p> <p>Physician's orders, dated 2/16/21, indicated, "...place Resident in droplet plus isolation..."</p> <p>The new admission Minimum Data Set (MDS) assessment, dated 1/25/21, indicated Resident N was cognitively intact.</p> <p>Resident N's care plan, date initiated 1/26/21, revised on 2/19/21, and current through 4/26/21, indicated "...resident is on droplet isolation due to at risk for COVID-19 related to potential exposure with recent hospitalization/admission from community..."</p> <p>During interview, on 2/19/21 at 2:45 p.m., the Director of Nursing indicated Resident N was placed in droplet isolation due to being readmitted to the facility from the hospital. The trash can was supposed to be located inside the Resident's room near the door. Currently, the census on the yellow zone (unknown COVID-19</p>				

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	<p>status) was 14.</p> <p>2b. On 2/19/21 at 2:00 p.m., observed Resident Q's door to be opened. Observed a sign posted on Resident Q's door. The sign indicated, "Yellow zone, transmission-based precautions, contact droplet, PPE [personal protective equipment] required...N95 mask - approved KN95...face shield or goggles...single gown - with each encounter gowns must be single use per resident...gloves." Inside Resident Q's room, observed a small uncovered trash can that was lined with a clear plastic trash bag. The trash can was located mid-way across the room from the door and no trash was visible inside the trash can. No other trash cans were observed in Resident Q's room or private adjoining restroom. At that same time, observed OT (Occupational Therapist) 5 inside of Resident Q's room wearing goggles, N95, gloves, and gown. During an interview at that time, OT 5 indicated the room had only one trash can and it was located mid-way across the room from the door. OT 5 indicated prior to exiting the isolation room he was to remove and discard the gown and gloves into the trash can located inside the Resident's room.</p> <p>The clinical record of Resident Q was reviewed at 2/19/21 at 2:35 p.m. Diagnosis included, but not limited to, right and left below knee amputation and frostbite.</p> <p>Physician's orders, dated 2/8/21, indicated, "...place Resident in droplet plus isolation..."</p> <p>Resident Q's care plan, date initiated 2/8/21, revised on 2/19/21, and current through 5/9/21, indicated "...resident is on droplet isolation due to at risk for COVID-19 related to potential</p>			

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	<p>exposure with recent hospitalization/admission from community..."</p> <p>During interview, on 2/19/21 at 2:45 p.m., the Director of Nursing indicated Resident Q was placed in droplet isolation due to being admitted to the facility from the hospital. The trash can was supposed to be located inside the Resident's room near the door. Currently, the census on yellow zone (unknown COVID-19 status) was 14.</p> <p>2c. On 2/19/21 at 2:00 p.m., observed Resident R's door to be opened. Observed a sign posted on Resident R's door. The sign indicated, "Yellow zone, transmission-based precautions, contact droplet, PPE [personal protective equipment] required...N95 mask - approved KN95...face shield or goggles...single gown - with each encounter gowns must be single use per resident...gloves." Inside Resident R's room, observed a small uncovered trash can that was lined with a clear plastic trash bag. The trash can was located mid-way across the room from the door and no trash was visible inside the trash can. No other trash cans were observed in Resident R's room or private adjoining restroom. At that same time, observed OT (Occupational Therapist) 5 inside of Resident R's room wearing goggles, N95, gloves, and gown. During an interview at that time, OT 5 indicated the room had only one trash can and it was located mid-way across the room from the door. OT 5 indicated prior to exiting the isolation room he was to remove and discard the gown and gloves into the trash can located inside the Resident's room.</p> <p>The clinical record of Resident R was reviewed at 2/19/21 at 2:35 p.m. Diagnosis included but not limited to, sepsis due to E. Coli (Escherichia</p>			

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	<p>Coli, bacteria infection); emphysema; acute bronchitis; and acute respiratory failure.</p> <p>Physician's orders, dated 2/11/21, indicated, "...place Resident in droplet plus isolation..."</p> <p>Resident R's care plan, date initiated 1/27/21, revised on 2/19/21, and current through 4/27/21, indicated "...resident is on droplet isolation due to at risk for COVID-19 related to potential exposure with recent hospitalization/admission from community..."</p> <p>During interview, on 2/19/21 at 2:45 p.m., the Director of Nursing indicated Resident R was placed in droplet isolation due to being re-admitted to the facility from the hospital. The trash can was supposed to be located inside the Resident's room near the door. Currently, the census on yellow zone (unknown COVID-19 status) was 14.</p> <p>2d. On 2/19/21 at 2:00 p.m., observed Resident S's door to be opened. Observed a sign posted on Resident S's door. The sign indicated, "Yellow zone, transmission-based precautions, contact droplet, PPE [personal protective equipment] required...N95 mask - approved KN95...face shield or goggles...single gown - with each encounter gowns must be single use per resident...gloves." Inside Resident S's room, observed a small uncovered trash can that was lined with a clear plastic trash bag. The trash can was located mid-way across the room from the door and no trash was visible inside the trash can. No other trash cans were observed in Resident S's room or private adjoining restroom. At that same time, observed MDS (Minimum Data Set) Coordinator inside Resident S's room wearing goggles, N95, gloves, and gown. MDS</p>				

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	<p>Coordinator walked from the middle of the Resident's room to the doorway and remained inside the room. During an interview at that time, the MDS Coordinator indicated the room had only one trash can and it was located mid-way across the room from the door. The MDS Coordinator indicated the PPE trash can should have been located inside and near the Resident's door or inside the adjoining restroom.</p> <p>The clinical record of Resident S was reviewed at 2/19/21 at 2:40 p.m. Diagnosis included but not limited to, frostbite with tissue necrosis (death of cells or tissues) of both feet and hands.</p> <p>Physician's orders, dated 2/18/21, indicated, "...place Resident in droplet plus isolation..."</p> <p>Resident S's care plan, date initiated 2/19/21, revised on 2/19/21, and current through 5/20/21, indicated "...resident is on droplet isolation due to at risk for COVID-19 related to potential exposure with recent hospitalization/admission from community..."</p> <p>During interview, on 2/19/21 at 2:45 p.m., the Director of Nursing indicated Resident S was placed in droplet isolation due to being admitted to the facility from the hospital. The trash can was supposed to be located inside the Resident's room near the door. Currently, the census on yellow zone (unknown COVID-19 status) was 14.</p> <p>During interview, on 2/19/21 at 4:00 p.m., the facility's Corporate Nurse indicated the facility lacked a specific facility policy that outlined where the PPE trash can was to be positioned in the Resident's room.</p> <p>On 2/19/21 at 4:10 p.m., the facility's Corporate</p>				

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	<p>Nurse provided a copy of the facility's Use of PPE While In The Facility document, dated 11/30/20, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...gowns must be disposed of when exiting the resident room..."</p> <p>On 2/19/21 at 3:00 p.m., a review of the CDC (Center for Disease Control and Infection Control) isolation guidelines, located at https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html, indicated, "...Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens."</p> <p>On 2/19/21 at 3:15 p.m., a review of the CDC (Center for Disease Control and Infection Control) isolation guidelines, located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html? CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html, indicated, "...Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room..."</p> <p>3.1-18(b)</p>			