This visit was for the Investigation of Complaint IN00352866 and IN00353485.

Complaint IN00352866- Substantiated. Federal/State deficiencies related to the allegations are cited at F684.

Complaint IN00353485 - Unsubstantiated due to lack of evidence.

Unrelated deficiencies are cited.

Survey dates: May 10, 11 and 12, 2021

Facility number: 012225
Provider number: 155780
AIM number: 200983560

Census Bed Type:
SNF/NF: 93
Total: 93

Census Payor Type:
Medicare: 9
Medicaid: 69
Other: 15
Total: 93

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality Review completed on May 14, 2021.
applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

Based on record review and interview, the facility fail to ensure a resident was transported to a cataract surgical appointment for 1 of 3 residents reviewed for quality of care. (Resident B)

Findings include:

On 5/10/21, at 11:00 a.m., Resident B's clinical record was reviewed. Diagnoses included, but not limited to: schizophrenia, chronic kidney disease stage 5, urinary retention and dementia.

Resident B was admitted on 3/23/21.

An admission Minimum Data Set (MDS) assessment, dated 3/24/21, indicated Resident B's cognitive status was severely impaired.

On 4/26/2021, Resident B's roommate was transported to Resident B's scheduled eye surgery and was accompanied by CNA 1. Resident B's daughter was going to meet them there at the eye center. Upon arriving at the eye center, the daughter indicated the resident with CNA 1 was not her father, not Resident B.

Review of the appointment book, on 5/11/21 at 11:30 a.m., indicated the resident's name, room number, CNA to accompany, and the name and directions to the eye center was noted for the date of 4/26/21.

Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during complaint survey on May 12, 2021. Please accept this plan of correction as the provider's credible allegation of compliance.

Corrective action for the residents found to have been affected by the deficient practice:
Resident has discharged from the facility.

Corrective action taken for those residents having the potential to be affected by the same deficient practice:
Director of Nursing has appointed a scheduler who is responsible for
During an interview, on 5/11/21 at 11:44 a.m., the Unit Manager (UM) where Resident B resided, indicated the transfer/transport was set up, Resident B's daughter was informed and information including the CNA who would accompany Resident B was placed in appointment book. Upon arrival to the eye center, the daughter indicated the resident was not her father, not Resident B. The CNA called the UM and informed her of the error. Transportation was requested by the UM and the eye center rescheduled Resident B's cataract surgery for 4/28/21.

During an interview, on 5/11/21 at 12:26 p.m., CNA 1 (who accompanied Resident B) indicated she was a new hire and was not familiar with a lot of the residents. She came in to work and got, who she thought, was Resident B ready for the transfer. She asked the nurses at the desk what Resident B looked like and they responded he had a white beard. CNA 1 gone down to Resident B's room and the room door did not have residents' names listed. She knocked on the door, went in, and the Resident in bed 2 (near the window) sat up. With the resident having a white beard, she asked if his name was [resident's name] to which he responded "yes." She proceeded to get him dressed placed him in his wheelchair, and rolled him to the nurses station (Resident B's roommate). She stopped at the nurses station to get the transfer paperwork and the nurses at the desk said "bye [resident's name]" as she rolled the resident to the transport van. When the CNA and the resident arrived at the destination, Resident B's daughter was waiting there, and indicated the resident with the CNA was not her father, not Resident B. The CNA then called the UM to advise the resident with her was maintaining transportation and the appointment schedule for all residents. This scheduler will ensure the right resident is going to the right appointment on a daily basis.

**Measures/systemic changes put into place to ensure the deficient practice does not recur:**
- Root cause analysis completed and determined that proper identification for residents is needed as an identifier on resident doors.
- Director of Nursing and Unit Manager to audit appointments daily in clinical meeting.

**Corrective actions to be monitored to ensure the deficient practice will not recur:**
- Director of Nursing and Executive Director will audit resident rooms to ensure name tags are in place for all residents.
- Facility audit to be completed by 6/1 to ensure all resident's have name tags on the doors. DON/ED will audit 10 resident rooms each week for name tags on doors for 4 weeks, then monthly x3 months. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine...
not Resident B. She indicated the UM would call for transport to bring them back to the facility.

On 5/12/21 at 4:00 p.m., the facility's Clinical Representative (CR) provided the transfer and discharge policy, dated 3/10/2017, and indicated it was the current policy being used. Review of policy did not indicate procedures related to transferring residents for appointments and the CR re-stated it was the only policy the facility had.

This Federal tag relates to Complaint IN00352866.

3.1-37(a)

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 when 100% compliance is achieved or if ongoing monitoring is required.
based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility 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, interview, and record review, the facility failed to ensure facility staff followed the guidance for implementing the correct wearing of personal protective equipment (PPE) / face masks for 15 of 93 residents who reside in the NF (nursing facility) reviewed for IC (infection control).

Findings include:

On 5/10/21 from 2:30 p.m. to 2:50 p.m., observed RN 1 standing at the medication cart near the isolation yellow zone (COVID status unknown droplet isolation precautions implemented) with a mask/PPE positioned below his chin. The mask was observed not to cover RN 1’s nose nor mouth. RN 1 was observed to make no attempt to bring the mask up to cover his nose and mouth. RN 1 continued to move around outside of the nurses station, to the 400 hallway, and to the medication cart; having passed 3 residents sitting in the hallway.

On 5/10/21 at 2:45 p.m., RN 1 was observed going in and out of the yellow zone 4 times without having his mask/PPE properly placed to cover his nose and mouth.

On 5/10/21 at 2:50 p.m., a CNA (Certified Nursing Assistant) trainee was observed standing in the 400 hall eating from a plate of food with F 880

Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: RN#1 and C.NA Trainee have been educated on the correct wearing of PPE / face masks.

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 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.

Policy: USE OF PPE WHILE IN THE FACILITY and Criteria for Covid 19 Isolation
NAME OF PROVIDER OR SUPPLIER

HOMEWOOD HEALTHCARE CENTER

SUMMARY STATEMENT OF DEFICIENCIES

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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 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 correct wearing of PPE / face masks.

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 occur for 6 weeks and until compliance is maintained. Infection Control Practices ensure correct wearing of PPE / face masks.

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.