STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155790	A. BUILDING 00 B. WING	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER HEALTHCARE CENTER	14751 CAREY ROAD CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. Survey dates: August 12, 2021. Facility number: 012548 Provider number: 155790 AIM number: 201023760 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 12 Medicaid: 52 Other: 18 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 19, 2021.	F 0000	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 Statement 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 a Focused Infection Control Survey on 8/12/2021. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.			

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

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	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

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	their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observations, interview, and record review, the facility failed to properly prevent the potential for exposure to COVID-19 by ensuring staff appropriately wore personal protective equipment (PPE) during resident care and housekeeping duties in droplet/contact isolation rooms, failed to ensure used PPE was discarded in designated trash cans, and full trash bags and cans used for soiled PPE in resident rooms were not overflowing for 18 of 18 residents observed for infection control (Residents 41, 33, 50, 61, 63, 66, 27, 28, 70, 1, 29, 65, 71, 11, 67, 75, 44, and 68). Findings include: 1. During an initial facility tour on 8/12/21 from 9:25 a.m. until 10:00 a.m., the following was observed:	F 0880	**F 880** **Corrective actions accomplished for those residents found to be affected 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:	09/08/2021

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	a. At 9:25 a.m., Licensed Practical Nurse (LPN) 8 was observed in Resident 41's room. A yellow sign was posted on the open door which indicated the resident was in "Droplet/Contact" isolation. The sign indicated, "...Gowns: to be worn inside of resident's room and changed between roommates... Gloves: are to be used when providing care..." At this time, LPN 8 was observed to have a blue isolation gown on, but it was not tied behind her neck, so that the gown draped open in the front. LPN 8 leaned over Resident 41 as she took the residents vital sings. She did not have on gloves. LPN 8 pulled off the untied gown and discarded it in a yellow trash can at the resident's door. She exited the room and used hand gel to sanitize her hands. At this time, she indicated, there were 4 newly admitted residents on the 4000 hall, and they were all in droplet isolation as a COVID-19 precaution. b. At 9:28 a.m., Qualified Medication Aid (QMA) 14 knocked on Resident 33's door and entered the room. A yellow sign was posted on the open door which indicated the resident was in "Droplet/Contact" isolation. QMA 14 did not sanitize his hands, put on an isolation gown, or gloves before he entered the room. c. On the 3000 Hall at 9:42 a.m., Housekeeper 7 was observed in Resident 50 and 61's room. He swept and mopped the floors. He was observed to have a blue isolation gown on, but it was not tied behind his neck or behind his back, so the gown hung lose and away from his body and dangled at his wrists. He exited the room after he pulled off the gown and discarded it in a yellow trash can at the door. He did not sanitize his hands after he left the room.		- Ensure staff involved are educated or appropriate way to dispose of contaminated items with potentially infectious agents. Ensure the potentially infectious agents are transported in biohazard containers and disposed of according to policy. Follow CDC and facility policy. Policy: Criteria Covid Tracking and Cohorting - 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, General Hand Hygiene CDC: PPE sequence Competency: AAPACN Personal-Protective-Equipment-PPE-Donning-and-Doffing, AAPACN Hand Hygiene Competency **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	

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	At 9:44 a.m., Housekeeper 7 partially donned (put on) a new isolation gown and entered Resident 63 and 66's room without sanitizing his hands. The isolation gown was not fastened so it hung lose to the middle of his chest and swished open down his back. He swept and mopped the resident's room. He exited the room after he pulled off the gown and discarded it in a yellow trash can at the door. He did not sanitize his hands after he left the room At 9:48 a.m., Housekeeper 7 partially donned a new isolation gown and entered Resident 27 and 28's room. He did not sanitize his hands. The isolation gown was not fastened so it hung lose to the middle of his chest and swished open down his back. He swept and mopped the resident's room. He exited the room after he pulled off the gown and discarded it in a yellow trash can at the door. He did not sanitize his hands after he left the room. At 9:51 a.m., Housekeeper 7 exited the 3000 Hall without sanitizing his hands. 2. On 8/12/21 at 12:29 p.m., Housekeeper 7 was observed in Resident 70's room. A yellow sign was posted on the open door which indicated the resident was in "Droplet/Contact" isolation. Housekeeper 7 did not have on an isolation gown, and he finished sweeping the resident's bathroom floor. He exited the room and did not sanitize his hands. 3. During a facility tour on 8/12/21 from 1:40 p.m., until 2:15 p.m., the following was observed: a. On the 3000 Hall at 1:41 p.m., the yellow trash cans for soiled PPE inside Resident 1, 29 and		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	

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	65's rooms were observed to be overfilled. Isolation gowns spilled over the top of the lid and touched the floors. b. At 1:42 p.m., Housekeeper 7 partially donned a new isolation gown and entered Resident 29 and 65's room without sanitizing his hands. The isolation gown was not fastened so it hung lose to the middle of his chest and swished open down his back. He exited the room after he pulled off the gown and discarded it in a yellow trash can at the door. He did not sanitize his hands after he left the room. At 1:44 p.m., Housekeeper 7 partially donned a new isolation gown and entered Resident 71's room without sanitizing his hands. The isolation gown was not fastened so it hung lose to the middle of his chest and swished open down his back. He exited the room after he pulled off the gown and discarded it in a yellow trash can at the door. He did not sanitize his hands after he left the room. At 1:51 p.m., Hospitality Aid 9 was observed in Resident 11's room. Her mask was observed pulled below her nose, and the isolation gown was not tied at her neck so that it hung lose to the middle of her chest. At 2:13 p.m., a full bag of trash, with soiled PPE (surgical masks, gloves, and isolation gowns) was observed left of the floor outside of Resident 67 and 75's room. 4. On 8/12/21 at 2:46 p.m., two nursing medication carts were observed at the 2000 Hall Nurse's Station, which was located in the common activity/dining area. Both medication cart trash cans were observed full and overflowed		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 execute proper donning and doffing of PPE, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection ensure staff execute proper hand hygiene prior to donning and after doffing PPE ensure used PPE is discarded in designated waste cans and full trash bags and cans used for soiled PPE in resident rooms are not overflowing 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 execute proper donning and doffing of PPE, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection	

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	with used blue isolation gowns. Residents 44 and 68 both sat in the common area. During an interview on 8/12/21 at 2:30 p.m., with the Administrator (ADM) and Director of Nursing (DON), the ADM indicated the facility was in outbreak precautions due to three staff members who had recently tested positive for COVID-19. The DON indicated, 2000 and 3000 Halls had been placed on quarantine and every resident was in droplet isolation as a precaution due to potential exposure from one of the staff members who had tested positive and had worked on those units. Additionally, there were 4 newly admitted residents in droplet precautions because they were new admits and had not been vaccinated against the COVID-19 virus. The DON indicated residents in droplet isolation had been placed in "yellow" rooms which meant, staff should follow instructions posted on the door for donning (putting on) and doffing (taking off) PPE. The DON indicated, isolation gowns should be tied both behind the neck, and behind the waist to completely cover the body, and staff should sanitize their hands before and after leaving resident rooms. On 8/12/21 at 2:45 p.m., the DON provided a copy of the yellow Droplet/Contact sign. The sign indicated, "...Gowns: to be worn inside of resident's room and changed between roommates... Gloves: are to be used when providing care...." During the survey entrance conference on 8/12/21 at 9:00 a.m., the ADM provided a copy of current facility policy. The policy was titled, "Infection Outbreak Management Plan" dated, 4/22/21. The policy indicated, "...Management During an Outbreak... Implementing droplet or		ensure staff execute proper hand hygiene prior to donning and after doffing PPE ensure used PPE is discarded in designated waste cans and full trash bags and cans used for soiled PPE in resident rooms are not overflowing **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.	

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	contact precautions where appropriate... Timely implementation of droplet precautions will aid in reducing transmission of respiratory transmission... implement the isolation protocol in the facility... Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC [Centers for Disease Control]..." A second policy titled, "COVID Tracking and Cohorting" dated 7/8/21 indicated, "...At risk Areas: full PPE is required upon entry into a patient room which includes N95 mask, eye protection, gown, and gloves... hands will be washed and or sanitized prior to entering a resident's room and upon exiting the room..." 3.1-18(b)(1)			