STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 the Investigation of Complaint IN00352845, and a COVID-19 Focused Infection Control Survey. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00348172 completed on March 19, 2021. Complaint IN00352845- Substantiated. Federal/State deficiencies related to the allegations are cited at F564, F880, and F882. Survey dates: May 4 and 5, 2021. Facility number: 011296 Provider number: 155763 AIM number: 200827620 Census Bed Type: SNF/NF: 30 Residential: 7 Total: 37 Census Payor Type: Medicare: 2 Medicaid: 20 Other: 15 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 6, 2021	F 0000	This plan of correction is to serve as North Ridge Village Nursing and Rehab's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by North Ridge Village Nursing and Rehab or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations. We respectfully request a paper review of this plan of correction.	
F 0564 SS=D Bldg. 00	483.10(f)(4)(vi)(A)-(D) Inform Visitation Rghts/Equal Visitation Prvl §483.10(f)(4)(vi) A facility must meet the following requirements:			

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

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	(A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences. Based on record review, and interview, the facility failed to ensure visitation rights, establishment and provision of Essential Caregiver and Comprehensive Caregiver programs were available for 1 of 11 Covid-19 fully vaccinated residents (Resident D). Findings include The facility policy titled "Indoor/Outdoor Visitation Policy and Procedure," revised 3/29/21, indicated "Policy Interpretation and Implementation: ... 5. Visitation days and times are subject to change based on current health	F 0564	· CORRECTIVE ACTIONS FOR AFFECTED RESIDENTS: *The Essential Caregiver & Comprehensive Caregiver Programs will be updated and implemented. Identified, affected resident will be provided the opportunity to have one family member/visitor designated as an essential caregiver to visit 2 times/week for 1 hour (upon completion of essential caregiver agreement. Comprehensive caregivers (Compassionate*	06/04/2021

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	conditions of residents, staffing, weather conditions, and PPE supply. ... 8. Visitation will be scheduled in increments of one (1) hour (If a visitor is late that decreases their 1-hour visit by how many minutes they are late, and this will also include the time it takes for screening). 9. Residents will be permitted one visit every week in order to allow all residents the opportunity to have a visit. ... 24. Outdoor visits (weather permitting) will occur over indoor visits. 25. If the facility develops any new facility-onset COVID-19 cases (as define per ISDH guidelines) or the county positivity rate is 10% or greater (as defined per CMS guidelines) the facility will stop indoor visitations per ISDH guidelines until further notice...." The facility policy titled "Essential Caregiver Policy and Procedure," dated 3/29/21, indicated "Policy Interpretation and Implementation: 1. Designation is at the discretion of the facility Administrator (or designee) and only upon agreement by the resident (and/or representative). 2. The Essential Caregiver Agreement will outline what support will be provided ... and designated time (not to exceed one hour). ... 13. Should the need arise to cohort residents by COVID-19 status, essential caregivers will only be allowed in "green" areas of the facility. ... 16. If the facility develops any new facility-onset COVID-19 cases (as define per ISDH guidelines) or the county positivity rate is 10% or greater (as defined per CMS guidelines) the facility will stop indoor visitations per ISDH guidelines until further notice...." During a confidential interview on 5/4/21 at 3:02 P.M., a resident's family members indicated the last indoor visit they were able to make was in March of 2021. The facility indicated to them no		*caregivers) will be permitted compassionate care visits as necessary. Additionally, The SSD will provide the affected resident family members with updated visitation policies including essential caregiver and comprehensive caregiver (compassionate caregiver).* · METHODS FOR IDENTIFICATION OF OTHER POTENTIALLY AFFECTED RESIDENTS: *All current resident families will be provided with updated visitation policies including essential caregiver and comprehensive caregiver (compassionate caregiver). Additionally, all current residents will be provided the opportunity to have one family member/visitor designated as an essential caregiver and/or comprehensive caregiver (compassionate caregiver) to visit 2 times/week for 1 hour (upon completion of essential caregiver agreement). Additionally, nursing staff (nurses, C.N.A.'S, QMA'S) will be educated regarding updated visitation policies.* · MEASURES TO PREVENT RECURRANCE: *During nursing department orientation, new nursing employees (nurses, C.N.A.'S, QMA'S) will be educated regarding*	

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	visits were allowed in April due to new staff positives and high county positivity; also the family had been informed no visits could take place until 14 days had passed with no new staff testing positive. The family member indicated since the beginning of April, new staff positives would always happen right around the end of the 14 days, so the facility would not allow indoor visits which resulted in no visits through the month of April. The family member indicated they had been asking about Essential Caregiver visits for them and the spouse of the resident since the program was introduced by the Indiana Department of Health (IDOH) but had always been told the Administrator and corporate had to approve it first. The family member indicated the Social Service Director (SSD) had told them the program would start back up when county positivity rates dropped, and the Administrator told them the facility had been following Centers for Disease Control (CDC) guidelines. The family member asked about compassionate caregiver visits due to the resident informing them they were depressed when the family spoke to the resident on 4/30/21. The facility had completed a Psychosocial Health Quote (PHQ) PHQ-9. The residnet scored a zero so the family was told the resident did not qualify for compassionate care visits. The family member indicated the resident may have had a urinary tract infection (typical with the resident's yelling out behaviors), the resident had been fully vaccinated for Covid-19, as had the resident's spouse. The clinical record for Resident D was reviewed on 5/5/21. Diagnoses included, major depressive disorder, other amnesia, and unspecified dementia. The record indicated Resident D had been calling out in an uncontrollable fashion on 4/30/21. The facility provided 1 on 1 care to		*visitation policies including essential caregiver and comprehensive caregiver (compassionate caregiver). All future residents/families will be provided updated visitation policies including essential caregiver and comprehensive caregiver (compassionate caregiver).* · CORRECTIVE ACTIONS MONITORING: *The SSD or designee will monitor all newly admitted residents to ensure essential caregiver and comprehensive caregiver (compassion caregiver) visitation policies are provided. Additionally, SSD or designee will provide a monthly report reflecting results of monitoring to the QAPI Committee with a goal to achieve and maintain 100% compliance for all new admissions for 6 months. The QAPI committee will review monthly and compare the actual percentage compliance with the percentage compliance goal of 100% and make any further necessary recommendations to ensure future residents and family members are provided with updated essential caregiver and comprehensive caregiver (compassionate caregiver) visitation policies, based on achieved compliance percentage if less than the 100% compliance*	

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	reassure resident they were ok and they would do what they could to help the family. The physician and the resident's Power of Attorney (POA) were notified., and the physician ordered a urinary analysis. On 5/3/21, the POA called the facility about a tentative psychiatric consult, and indicated he did not want the resident to have a psychiatric consult, nor did he want any medications changed at that time. The facility's Long Term Care (LTC) Respiratory Surveillance Line List indicated Employee 12 had tested positive for Covid-19 on 4/1/21 so facility began outbreak testing of staff and employees. Employee 13 tested positive on 4/5/21, Employee 14 tested positive on 4/15/21, and Employee 5 tested positive on 4/26/21. During an interview on 5/4/21 at 11:57 A.M., the Director of Nursing (DON) indicated the facility had not seen the compassionate caregiver guidance, and were not clear on how to allow touch while staying socially distanced. She indicated the facility was still doing outbreak testing so no indoor visits would be allowed at this time. During an interview on 5/4/21 at 1:57 P.M., the DON indicated a 3-way call with herself, the facility Administrator, the Indiana Department of Health (IDOH) and the family of Resident D about the visitation guidelines on 4/28/21 indicated IDOH assured the family the facility had been following visitation guidelines. During an interview on 5/5/21 at 10:33 A.M., the SSD indicated all visits had to be outdoor visits since 4/1/21 due to staff testing positive for Covid-19. She was told if staff were positive that only outdoor visits were permitted. In response to		*goal and until 100% compliance is maintained for 6 months.*	

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	the Indoor/Outdoor policy stating residents would be permitted one visit per week, the SSD indicated the facility had not had many visitors so some residents were doing more than 1 visit per week. In response to the Indoor/Outdoor policy stating outdoor visits would occur over indoor visits, the SSD indicated she was not sure what that meant. The SSD indicated the facility had not yet started the Essential Caregiver program as they had been waiting for guidance from the Administrator and corporate. The facility had also been told the program could not be done if staff or residents were positive. She indicated the last Covid-19 positive resident was in mid-December 2020 and most recent staff was April 2021 so there would have been an opportunity to start the program during Janiary, February and March. The SSD indicated the Essential Caregiver and Compassionate Caregiver were the same program. A Grievance Form dated 4/28/21 indicated the family of Resident D wanted to know why the spouse could not go into the facility as an essential caregiver. The form indicated the facility had called IDOH but they had not received a response back from IDOH. A Care Plan/[IDOH] Meeting Concerns form dated 4/28/21 indicated family members of Resident D said she was depressed. The SSD then indicated the resident was not showing signs/symptoms of depression at the facility, her husband visited weekly outdoors, and had window visits daily. On 4/18//21 the resident's PHQ-9 score was a zero. The resident went out every Wednesday with family for excursions. The form was signed by the SSD. During an interview on 5/5/21 at 2:33 P.M., the Administrator indicated the facility believed the			

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	compassionate and essential caregivers were the same thing according to the CDC guidelines, and that they did not have a policy for compassionate caregiver. This citation is related to complaint IN00352845.			
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. 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			

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	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 record review, observation and	F 0880	**What Corrective Action(s) Will**	06/04/2021

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	interview, the facility failed to ensure failed to implement and maintain infection control practices during a pandemic, to mitigate the spread of infection for 4 of 4 unvaccinated residents (Resident L, Resident M, Resident N, and Resident O), and failed to ensure complete and accurate screening for 1 of 1 employee upon arrival for work (Employee 5). Findings include The facility policy dated as revised July 2016 and titled "Emergency Procedure-Pandemic COVID-19," indicated "Policy Interpretation and Implementation ... 6. All prospective residents and employees shall be screened to identify exposure to novel COVID-19. ... Infection Prevention and Control ... Certain Phases of a Pandemic Alert Should Include Specific Precautions: ... 2. When a novel strain of COID-19 [sic] is increasing and sustaining human-to-human spread in the United States and cases are occurring in the facility's state: a. All prospective residents and employees will be screened to identify exposure to novel COVID-19. ... b. Residents, employees, ... and visitors will be evaluated daily for symptoms. Employees will be instructed to self-report symptoms and exposure. ... j. Residents ... will be cohorted as necessary...." 1. During observation on 5/4/21 at 10:08 A.M., Employee 3 was in the activity room with her mask and face shield on playing hangman with 3 residents. Resident H, Resident L, and Resident M were all present and not wearing masks. Resident H and Resident M were sitting in their wheelchairs approximately 1 foot apart. The facility failed to ensure activities were discontinued during outbreak testing for		**Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents will be affected by this alleged deficient practice. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All staff will be educated on proper mask donning and doffing, including proper type of mask to be worn, with return demonstration. All staff will be educated on proper face shield donning and doffing, with return demonstration. All staff educated on 5/27/21 & 5/28/21 in regard to guidelines to follow during outbreak testing and daily screening of staff and visitors. A Root Cause Analysis was completed (attachment A). The LTC Infection Control Self-Assessment has been updated to reflect current status of facility (attachment B). All staff will be educated in regard to any area	

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	non-vaccinated residents and failed to ensure the 3 residents were protected with masks. During an interview on 5/4/21 at 11:20 A.M., Employee 3 indicated small group activities began in January and usually only 2-3 residents showed up for activities. She also indicated she did not know who was vaccinated or not and the residents were usually good about spacing. Employee 3 indicated Resident M moved her wheelchair close to others a lot so she watched for that to remind the resident to move when needed. During observation on 5/4/21 at 11:50 A.M., 3 residents were observed in the main dining room waiting for lunch. Resident H was at the table with Resident N and Resident O talking with them before moving to his own table. None of the residents had masks on. The facility failed to ensure communal dining was discontinued during outbreak testing for non-vaccinated residents. The facility list dated 5/4/21 indicated the following residents observed above had not vaccinated for COVID-19 due to having declined the vaccine Resident L, Resident M, Resident N, and Resident O. 2. The facility's Long Term Care (LTC) Respiratory Surveillance Line List indicated Employee 5 tested positive on 4/26/21. The "Employee Screening Tool- Fit For Duty" log sheet dated 4/26 at 9A (9 A.M.) indicated Employee 5 had answered Y [yes] that he was currently ill and Y that he had symptoms of a cold, cough, short of breath or temporarily lost sense of taste or smell and or had symptoms of nausea/vomiting or diarrhea. Per the directions on		indicated on the facility assessment as an area of needed improvement. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will complete daily IP rounds on scheduled workdays for 6 months or until compliance is maintained. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for 6 months and the plan will be adjusted accordingly.	

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	the bottom of this log sheet, it indicated "If YES to any of the above questions-STOP and see the IP for direction. ... **If you are feeling ill- you SHOULD NOT report for duty." The screening tool failed to indicate that someone had screened Employee 5 prior to the employee working. During an interview on 5/5/21 at 1:57 P.M., the Director of Nursing (DON) indicated employees should not screen themselves in, and if they were having symptoms, they should not report to work. She indicated she tested Employee 5 on 4/26 but he had not reported any symptoms and had indicated he was fine. She indicated Employee 5 stayed in the maintenance office the majority of that day. 8 of 10 other employee screening logs failed to indicate someone had screened employees in to work on 4/1/21 Employee 19, 4/22/21 Employee 17, 4/26/21 Employees 3, 5 and 15, 4/29/21 Employee 16, 4/30/21 Employees 18 and 19; and 2 of 2 failed to contain a date and time for Employees 21 and 22. On 4/5/21 the Administrator's log in sheet failed to have any symptom questions answered. This citation is related to complaint IN00352845. 3.1-18(b)(3)			
F 0882 SS=D Bldg. 00	483.80(b)(1)-(4)(c) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must:			

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	§483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. Based on record review and interview, the facility failed to ensure an Infection Preventionist (IP) was on staff at least part time to oversee the infection prevention and control program. Findings include The facility policy titled "Infection Prevention and Control Program," revised August 2016, indicated "Policy Interpretation and Implementation 1. Coordination and Oversight a. The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist)...." The facility job description titled "QAPI- Role of the Infection Preventionist," revised April 2014, indicated "Duties and Responsibilities to the	F 0882	1. CORRECTIVE ACTIONS FOR AFFECTED RESIDENTS: *A part-time, Infection Preventionist will be designated to complete the necessary training and oversee the facility infection control program and participate as a member of the QAPI Committee. Additionally, the staff will be notified of the designated Infection Preventionist.* 2. METHODS FOR IDENTIFICATION OF OTHER POTENTIALLY AFFECTED RESIDENTS: *A part-time Infection Preventionist will be designated to complete the*	06/04/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	05/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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	QAPI Program include, but are not limited to ... 20. Others as required, including QAPI, or that may become necessary to ensure that the prevention and control of communicable diseased can be provided at all times." During entrance on 5/4/21 at 9:15 A.M., the Director of Nursing (DON) and Administrator indicated the previous administrator was the current IP. During an interview on 5/4/21 at 11:25 A.M., the DON indicated she had been here about 10 months and was still working on completing the IP modules to become the IP, but the previous administrator was the current IP for the facility. The employee list provided on 5/4/21 failed to indicate the previous administrator was an employee of the facility. During an interview on 5/4/21 at 11:00 A.M., Employee 23 indicated she did not know who was the IP. During an interview on 5/4/21 at 2:50 P.M., Employee 6 indicated she did not recall who was the IP. During an interview on 5/4/21 at 2:55 P.M., Employee 11 indicated she believed the housekeeping supervisor was the IP. During an interview on 5/5/21 at 10:33 A.M., Employee 7 indicated the previous administrator was the IP and that she was here 1 time a week to help the current administrator with things. This citation is related to complaint IN00352845.		*necessary training and oversee the facility infection control program and participate as a member of the QAPI Committee. Additionally, the staff will be notified of the designated Infection Preventionist.* 3. MEASURES TO PREVENT RECURRANCE: *Upon a future vacancy of the position, a designee will be appointed, until another person can be hired/trained as the infection preventionist.* 4. CORRECTIVE ACTIONS MONITORING: *The administrator will designate a part-time, qualified infection preventionist and/or designee who will oversee the infection control program and serve as a member of the QAPI Committee and provide necessary monthly monitoring reports of the infection control program.*	