STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK RESIDENTIAL CARE	2075 RIPLEY ST LAKE STATION, IN 46405

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00366671 and IN00358647. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00366671 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00358647- Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 22 and 23, 2021. Facility number: 001136 Residential Census: 96 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/29/21.	R 0000		
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to maintain a clean and sanitary environment in the Dining Room for 1 of 1 dining rooms observed. (Dining Room) This had the potential to affect all 96 residents who ate in the Small Dining Room.	R 0154	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The Administrator went into dining room and refilled the container	01/23/2022

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

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

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	Finding includes: During the clean up from the lunch service on 11/22/21 at 12:39 p.m., Dietary Aide 1 was observed to have wiped down the lunch tables with a solution in a red bucket. Observation and interview with Cook 1 on 11/22/21 at 12:39 p.m., indicated the solution in the red bucket was quaternary ammonium (a sanitizing solution). Cook 1 used a test strip to check the sanitization level of the red bucket that was in use. The sanitization level was not tested as a measurable sanitizing level. The packaging on the test strips indicated they had expired on August of 2019. Cook 1 was unaware of what the sanitization level should have been. Interview with the Administrator on 11/22/21 at 2:14 p.m., indicated the testing strips were too old to register. A policy titled, " Dietary, Sanitizing Solution for Cleaning Cloths," was provided by the Administrator on 11/22/21 at 2:14 p.m. This current policy indicated, "Procedure:...3. Test the sanitizing strength by dipping a test strip into the solution. 4. By matching the color coding on the container, the test strip should measure [blank] ppm (part per million)...."		used for cleaning and sanitizing the tables in the dining room. The proper levels of pre measured sanitizer as recommended by the vendor to ensure the tables were clean and sanitized was used. The Administrator obtained measurable sanitizer strips the next morning for usage by the dietary department that were current and had a 2022 expiration date. The new strips were checked and the sanitization level was checked and it was correct using the same levels of pre measured of sanitizer from the day previous when checked by the surveyor. The expired strips was also used to check and although it had an expiration date of 2019, it measured the sanitizer correctly. The 2019 sanitizer strips were disposed of at that time. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. 3,What measures will be put into	

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			place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Administrator will in-service the Dietary Manager as well as the Dietary and Activities staff about the proper usage of sanitizer strips to check the sanitation bucket when cleaning the tables in the dining rooms before and after meals to ensure that the sanitation bucket is at the proper sanitization level. the Dietary and Activities Staff will also be in serviced about checking the expiration dates on the sanitizer strips to ensure they are not expired and to notify the Dietary Manager immediately if strips are near expiration date. The Administrator will in service the Dietary Manager about checking the expiration dates on the sanitizer strips to ensure that they aren't expired. 4. How the corrective action will be monitored to ensure the deficient practice will not recur? The Dietary Manager will check the sanitation bucket weekly to ensure the sanitization level of sanitation buckets are at proper	

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			levels to clean and sanitize tables in the dining rooms for three months and then randomly check to ensure sanitization levels are at proper levels. 5. By what date the systemic changes will be completed. January 23, 2022	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to distribute food under sanitary conditions related to a food during lunch service left uncovered on the food cart. This had the potential to affect the 27 residents who received food from this food cart. Finding includes: During the lunch service on 11/22/21 at 12:09 p.m., Dietary Aide 1 was observed to have offered the same uncovered individual bowls of bean salad to the residents in the Small Dining room from a serving cart. While delivering the uncovered servings of bean salad, Dietary Aide 1 was observed to push the bean salad cart throughout the entire dining room. Interview with Dietary Aide 1 on 11/22/21 at 12:15 p.m., indicated she was going to put the	R 0273	1. What corrective will be accomplished for those residents found to have been affected by the deficient practice. After the surveyor interviewed the Dietary Aide 1, the Dietary Aide 1, who was a new Dietary Staff member, informed the Administrator of the interview. The Administrator then informed Dietary Staff to discard the leftover bean salad because it had been exposed. The Administrator informed Dietary Aide 1 that she couldn't serve the bean salad because it was exposed and that all foods must be covered at all times when	01/23/2022

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	remainder of the bean salad back into the refrigerator for the next group of residents. She was unaware the bean salads were to be covered.		pushing a cart in the dining room when serving. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Dietary Manager will in-service all Dietary Staff on the proper serving techniques when in the dining room which will include covering all foods when moving carts in dining room during serving times. 4.How the corrective action will be monitored to ensure the deficient practice will not recur what quality assurance program will be put into place. The Dietary Manager and/or	

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			designee will monitor the dining room weekly for three months during mealtimes to ensure that the meals are being served properly and that all foods are covered during serving times. After three months the Dietary Manager and/or designee will randomly check the Dietary Staff during serving times to ensure they are serving food properly covered. 5. By what date the systemic changes will be completed. January 23, 2022	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.			
	Based on record review, observation and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19 related to lack of eye	R 0407	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	01/23/2022

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	protection for employees within 6 feet of residents, staff not wearing proper PPE (Personal Protective Equipment) while performing the POC (Point Of Care - rapid test to detect the COVID-19 virus) tests on residents (Housekeeping 1 and Director of Nursing) and having an unvaccinated resident not in Transmission Based Precautions (TBP) during a COVID-19 outbreak, which had the potential to affect all 96 residents who resided in the facility. The facility also failed to monitor residents with and without the COVID-19 virus for 3 of 3 residents reviewed for infection control. (Residents T, D and V) Findings include: The facility COVID-19 outbreak started on 11/11/21: On 11/22/21 at 10:30 a.m., the CDC (Centers for Disease Control and Prevention) COVID-19 Data tracker, indicated the community transmission level was red/high transmission rate. 1. On 11/22/21 at 10:23 a.m., Housekeeper 1 was observed entering multiple residents' room on the 200 hallway. She had spoken to the residents within 6 feet without wearing eye protection. She indicated she was unaware eye protection was needed. 2. On 11/23/21 at 9:21 a.m., the DON was observed POC testing residents for the COVID-19 outbreak. One resident was observed to have walked in to the testing room, the DON sanitized her hands and donned gloves. The resident pulled down his mask and the DON swabbed one nostril and then the other nostril.		Housekeeper 1 had on hard plastic protective eyewear/face shield as well as a N95 mask but was told by surveyor that the protective eyewear she was wearing was unacceptable. Housekeeper 1 was given a protective face shield to wear by the Director of Nursing. Employee had been in-serviced prior to survey that face shields and N95 masks had to be worn during an outbreak, and that masks had to be worn at all times. In addition, Housekeeper 1 had been in-serviced about maintaining safe distancing while working. Housekeeper was counselled on the same day about wearing protective eyewear and also maintaining six feet of social distancing. DON has worn disposable gowns since 11/23/2021. Resident T was placed in a private room on quarantine unit. Resident D received continued monitoring for worsening of symptoms. Resident V will be monitored with vital signs for symptoms of Covid 19 Virus.	

She then removed her gloves and hand sanitized. The other resident left the room and the next resident entered and pulled down his mask. The DON donned gloves and completed the POC test. The DON did not have the proper PPE of a gown on while testing the residents. Interview with the DON at that time, indicated she had forgotten to put on a gown while testing the residents.

The COVID-19 Infection Control Guidance in Long-term Care Facilities for Core Principles of Infection Control, dated 9/28/21, indicated "...all Health Care Professionals (HCP) should wear eye protection for resident care when community transmission is substantial or high.

PPE includes:
o Masks and face shield may be used for the entire shift if not wet or visibly soiled.
o Residents should be wearing masks when within 6 feet of the HCP.
o HCP may only remove mask to eat or drink. It is expected that they are more than 6 feet away from other HCP and residents while the mask is removed.
o Standard precautions (wearing of gown and other PPE as needed per individual resident needs) should be followed: Standard Precautions for All Patient Care (CDC 1.26.16)...."

3. Resident T's record was reviewed on 11/23/21 at 9:30 a.m. Diagnoses included, but not limited to, schizophrenia (affects a persons ability to think, feel, and behave clearly)

His vaccination status indicated he was unvaccinated for COVID-19 vaccine.

His record lacked an indication of daily monitoring of the COVID-19 virus.

2. How will the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All the residents have the potential to be affected by the alleged deficient practice.

3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.

Director of Nursing will in-service all staff on proper usage of PPE equipment and donning of PPE.

Director of Nursing will in-service Nursing Staff on monitoring all residents daily for signs if symptoms of Covid virus by taking daily vital signs.

Director of Nursing will in service Nursing staff on placing a resident that has not been vaccinated in quarantine if there is an outbreak of Covid 19 virus in the facility and will ensure Transmission Based Precautions are used.

4. How the corrective action will

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	Resident T was observed on 11/23/21 at 10:00 a.m. in his room, with his roommate. No sign for TBP was on the door and there was no isolation cart with supplies for a TBP room observed. On 11/23/21 at 10:10 a.m., an overheard page was heard calling Resident T to the Nurse's Station. On 11/23/21 at 10:15 a.m., Resident T was observed in the hallway walking to the Nurse's Station. He was standing within 6 feet of another resident. The other resident was observed pulling his mask down while yelling at the Nurse's Station. Interview with the Director of Nursing (DON) on 11/23/21 at 11:04 a.m., indicated she was unaware that Resident T was to be in TBP during this COVID-19 outbreak and that he was to be monitored for COVID-19 signs and symptoms. 4. Resident D's record was reviewed on 11/23/21 at 2:40 p.m. Diagnoses included, but not limited to, major depressive disorder. Resident D was positive for the COVID-19 virus on 11/11/21, after returning from the hospital. The record lacked an indication of frequent monitoring of worsening signs and symptoms for the COVID-19 virus. Interview with Medical Assistant 1 on 11/23/21 at 2:54 p.m., indicated only on 11/11, 11/12 and 11/14/21 were vital signs completed and those lacked oxygen saturation monitoring. Interview with the DON on 11/23/21 at 4:00		be monitored to ensure the deficient practice does not recur,i.e. what quality assurance plan will be put into place. Housekeeping Supervisor will monitor Housekeeping staff weekly for six months to ensure that staff is wearing the proper PPE while working and maintaining six feet of social distancing, Thereafter Housekeeping Supervisor will randomly check to ensure Housekeeping staff is wearing the proper PPE and maintaining six feet of social distancing while interacting with the residents. Director of Nursing and/or designee will monitor staff using PPE on a daily basis. Staff not using PPE will be disciplined and/or terminated for refusal to wear the proper PPE. Director of Nursing and/or designee will ensure that resident's vital signs are taken daily to monitor for signs and symptoms of Covid 19 virus. 5. By what date the systemic changes will be completed. January 23, 2022	

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	p.m., indicated the resident should have been monitored with vital signs and oxygen saturation level every shift. 5. Resident V's record was reviewed on 11/23/21 at 11:15 a.m. Diagnoses included, but not limited to, schizoaffective disorder (mental health disorder and mood disorder) The record lacked an indication of being monitored for signs and symptoms of the COVID-19 virus. Interview with the DON on 11/23/21 at 4:00 p.m., indicated she was unaware to monitor residents daily for signs and symptoms of COVID-19 virus. Long-term Care COVID-19 Clinical Guidance,dated 9/28/21, indicated: "...Option 2: If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility). Unvaccinated residents and HCP: o Unvaccinated residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities. o Close contacts, if known, should be managed as described in Exposure Section. · Fully vaccinated residents and HCP: o Fully vaccinated residents should be tested; they do not need to be restricted to their rooms			

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	or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection. o For guidance about work restriction for fully vaccinated HCP who have higher-risk exposures, refer to Interim U.S. Guidance for Managing Healthcare Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2 (CDC 9.10.21). o In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for fully vaccinated residents and work restriction of fully vaccinated HCP with higher-risk exposures · If no additional cases are identified during the broad-based testing, room restriction and full PPE use by HCP caring for unvaccinated residents can be discontinued after 14 days and no further testing is indicated. · If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated residents, until there are no new cases for 14 days. o If antigen testing is used, more frequent testing (every 3 days), should be considered...."			