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	09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUGAR GROVE SENIOR LIVING COMMUNITY	5865 SUGAR LN PLAINFIELD, IN 46168

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00362002. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00362002 - Unsubstantiated due to lack of evidence. Survey dates: September 20 and 21, 2021 Facility number: 012394 Residential Census: 111 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 5, 2021.	R 0000		
R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals. Based on observation, interview, and record review, the facility failed to implement a program to receive, respond to, and track grievances for 3 of 3 months of grievances reviewed. Findings include:	R 0041	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of	10/15/2021

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

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	On 9/20/21 at 9:56 a.m., grievance records from 6/1/21 to 9/20/21 were requested. No grievances were provided. During an interview on 9/20/21 at 10:34 a.m., Resident S complained that staff refused to wear masks, particularly in the kitchen. He indicated he had complained directly to the staff and told them to wear their masks at all times, but they ignored him, so he complained to the Executive Director (ED). The ED said he would take care of it, but nothing happened, and the staff still refused to wear their masks. Resident S indicated, "They get to go out in public to stores and what not. Who knows what they come into contact with? Even if they are vaccinated, they can still carry it. They can protect us by wearing their masks, but they don't." During an interview on 9/20/21 at 11:25 a.m., a family member of Residents Qq and Rr indicated, she and other family members had expressed concerns to the facility staff and leadership multiple times. Neither she, other members of her family, nor the residents had ever received a response. She filed a grievance through the facility website, but never heard anything back. She had not been informed of the facility's grievance process. The Resident Committee met, and regularly voiced concerns and complaints to the facility leadership, but nothing was ever done, "they just get lip service". On 9/20/21 at 12:10 p.m., Resident H entered the dining room. She sat at a table, put her hand up and flagged the Dietary Manager. Resident H indicated out loud, across the dining room, "[Cook 15 still doesn't have her mask up!" During an interview on 9/20/21 at 12:11 p.m., Resident H indicated, it had been an ongoing		deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. **R041—Residents' Rights Deficiency** (a) The grievance procedure was re-implemented at the Community as of 9/22/21. (b) All residents have potential to be affected by alleged deficiency. (c) All department heads were trained on the components and importance of the grievance procedure on 9/22/21. (d) Grievances are being discussed each day in morning meeting and followed up on a grievance form. Also, a weekly audit of the grievance binder will be conducted X4 weeks by Executive Director/Designee to ensure this process is in place. (e) Results of audits will be reviewed with community management for identified issues and need to extend or expand audits. Date of Correction: 10/15/21	

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	problem that staff would not wear their masks. She had talked to the ED about her complaint, but nothing changed. Resident H indicated, "I know they are hot [wearing a mask], and I'm sorry for that, but this is our health!" During an interview on 9/20/21 at 1:48 p.m., the Regional Registered Nurse (RN) indicated she did not have access to grievances and state reportables. The ED handled the grievances and reportables, and he no longer worked at the facility as of that morning. During an interview on 9/21/21 at 2:15 p.m., the Regional Director of Operations (RDO), indicated the facility did have formal grievance procedure, but he had not been able to locate a specific policy. The facility procedure for grievances provided a tool for residents and/or family to share their concerns and ensured that leadership would follow up on those concerns to resolves them as best as possible. Although the facility had a grievance process/procedure, it appeared that the previous ED had not documented any grievances for the past several months.			
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview, and record review, the facility failed to follow CDC (Centers for Disease Control) guidance during a pandemic and prevent and contain exposure to COVID-19 for 2 of 2 days of infection control observations when residents in isolation (Residents F, G, and	R 0406	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion	10/15/2021

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	D) were not assessed for signs and symptoms of COVID-19 and signage was not placed on residents' apartments to alert visitors the residents were in transmission-based precaution isolation, COVID-19 vaccination records were not maintained, contact tracing was not completed following positive COVID-19 results in the facility for staff and residents (Cook 28, PCA 27, and Resident D), staff failed to wear face masks appropriately while working in the facility, staff failed to perform hand hygiene, and the facility failed to notify residents, family members/ responsible parties, and the state health department of a COVID-19 outbreak in the facility. Findings include: 1. a. On 9/20/21 at 12:40 a.m., Resident D's apartment was observed. The door to the apartment was closed, and there was a sign on the door that indicated the resident was in Airborne/ Contact precautions. A plastic storage bin was set outside the apartment door in the hallway and contained disposable exam gloves, N95 face masks, face shields, and disposable gowns. No hand sanitizer was observed on or near the storage bin or the resident's apartment door. During an interview on 9/20/21 at 9:56 a.m., the Director of Nursing (DON) indicated, Resident D was on transmission-based precautions because she tested positive for COVID-19 on 9/17/21. Resident D was tested as part of facility wide outbreak testing, following a COVID-19 positive staff member (PCA 27). The DON indicated Resident D had been quarantined to her apartment since she tested positive on 9/17/21. During an interview on 9/20/21 at 1:48 p.m., the DON indicated, Resident D was not vaccinated for		stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. **R406—Infection Control Offense** (a) A process was re-implemented on 9/22/21 to monitor all residents for s/s COVID-19 per CDC guidance. Residents without suspected or confirmed COVID-19 are monitored daily for s/s COVID-19 including fever (temperature above 100.0 degrees Fahrenheit), and symptoms of COVID-19 including oxygen saturation. Residents with suspected or confirmed COVID-19 infection are monitored each shift including a full set of vital signs (B/P, respirations, temperature, heart rate, oxygen saturations) and respiratory assessment. IDOH signage (stoplight signage) has been printed from the IDOH website and is available for use as there are residents that may be suspected of or have a current COVID-19 infection. Routine and outbreak testing is once again reported through the Indiana RedCap site, and a process has been implemented to notify residents, family	

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	COVID-19. Contact tracing was not completed for PCA 27, so she was not sure if Resident D had contact with the positive staff person. On 9/21/21 at 11:54 a.m., Resident D's record was reviewed. The resident's face sheet lacked documentation of the date the face sheet was completed, the resident's move in date, and medical diagnosis. Documentation from a previous health care facility indicated Resident D had medical diagnoses to include, but not limited to, anemia, acute embolism and thrombosis of left femoral vein (blood clot in the left leg), and major depressive disorder. An undated document titled, "General Admission Orders" lacked documentation of any order related to COVID-19 symptom monitoring, isolation, COVID-19 testing, or vital sign assessment. The space for, "MD Signature" was blank. A document titled, "Resident Monthly Weights and Vital Signs" indicated Resident D's blood pressure, heart rate, respirations (the number of breaths in and out per minute), and temperature were checked once in August and once in September. The record lacked documentation of which dates in August and September the vital signs were assessed. The record lacked documentation Resident D's oxygen saturation (the amount of oxygen circulating in the blood) was assessed. The record lacked documentation of COVID-19 symptom monitoring. On 9/21/21 at 2:24 p.m., the DON provided a document and indicated it was the COVID-19 testing tracking for the residents. The document indicated, Resident D tested negative on 9/14/21,		members/responsible parties via email. All COVID testing is being tracked by the Director of Nursing and was implemented upon her hire date of 9/7/21. All screening records for residents, visitors and staff including staff tests conducted elsewhere, are being retained at facility appropriately according to regulatory standards. A system of Contact Tracing for positive staff and residents has been re-implemented, for which the DON/designee is responsible for monitoring moving forward. (b) All residents could potentially be affected by the alleged deficient practices of not assessing for s/s COVID infection, COVID records not being maintained, and contact tracing not being conducted adequately for staff and residents. In addition, all residents could be affected by staff improperly utilizing or not utilizing required PPE. (c) Clinical staff has been re-educated as of 9/24/21 to the appropriate usage of isolation signage. Re-education on hand hygiene and proper PPE usage has been completed for staff as of 10/1/21. (d) DON/designee will conduct random audits 5x/weekly for 4 weeks, and then 1x/weekly for 4 weeks of resident, staff and visitor Covid screenings. DON/designee will observe/audit hand hygiene for	

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	and tested positive on 9/17/21. On 9/21/21 at 2:45 p.m., documentation of vital signs and COVID-19 symptom monitoring for Resident D was requested. It was not provided. b. On 9/20/21 at 2:57 p.m., the DON provided a map of the facility and indicated Resident G was in isolation for 14 days because she was a new admission and was not vaccinated for COVID-19. On 9/21/21 at 12:26 p.m., Resident G's record was reviewed. The resident's face sheet, dated 8/29/21 , indicated Resident G had medical diagnoses to include, but not limited to, spinal stenosis (a condition where the spinal column narrows and compresses the spinal cord), lupus (an autoimmune disease), rheumatoid arthritis (chronic inflammatory disease that affects the joints), and asthma. On 9/21/21 at 2:24 p.m., the DON provided a document and indicated it was the COVID-19 testing tracking for the residents. The document indicated, Resident G tested negative on 9/20/21. No other COVID-19 testing, or result documentation was provided. On 9/21/21 at 2:45 p.m., documentation of vital signs and COVID-19 symptom monitoring and physician orders for Resident G was requested. They were not provided. c. On 9/20/21 at 2:57 p.m., the DON provided a map of the facility and indicated Resident F was in isolation for 14 days because she was a new admission and was not vaccinated for COVID-19. On 9/21/21 at 12:17 p.m., Resident F's record was reviewed. The resident's face sheet indicated her		staff 5x/weekly for 4 weeks, and then 1x/weekly for 4 weeks. (e) Results of audits will be reviewed with community management for identified issues and need to extend or expand audits. Date of correction: 10/15/21	

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	move in date was 9/16/21. Resident F's medical diagnoses were A. Fib (Atrial fibrillation, an irregular and often rapid heart rate that can increase your risk of strokes, heart failure and other heart-related complications) and Factor V (an inherited disorder of blood clotting that causes abnormal blood clot in the leg or lungs). A document titled, "General Admission Orders", dated signed by the physician on 9/9/21, lacked documentation of any order related to COVID-19 symptom monitoring, isolation, COVID-19 testing, or vital sign assessment. A document titled, "Resident Monthly Weights and Vital Signs" indicated Resident F's blood pressure, heart rate, respirations (the number of breaths in and out per minute), and temperature were checked once in September. The record lacked documentation of which date the vital signs were assessed in September. The record lacked documentation Resident F's oxygen saturation (the amount of oxygen circulating in the blood) was assessed. The record lacked documentation of COVID-19 symptom monitoring. On 9/21/21 at 2:45 p.m., documentation of vital signs and COVID-19 symptom monitoring for Resident F was requested. It was not provided. During an interview on 9/21/21 at 3:46 p.m., the DON indicated the facility did not have record of vital signs or COVID-19 symptom monitoring for Residents D, F, and G. She indicated the residents should have been monitored. On 9/21/21 at 2:25 p.m., the DON provided a policy titled, "Guidance for Reopening Community to Visitation", dated 8/10/21. The Regional Director of Operations (RDO) indicated, this was the			

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	facility COVID action plan, and was the policy in use by the facility at that time. The policy indicated, "Regardless of the testing requirements, all communities [facilities] should have infection control practices in place: daily temperature checks, health assessment questionnaire for all Residents, Staff, and Visitors ...The community must obtain an order from a physician, physician assistant, nurse practitioner, pharmacist (in accordance with State law) to do the tests for both PCR and Rapid antigen testing ...For ALF [assisted living facility]/ MC [memory care]/ RCF [residential care facility], there is no medical director. For each patient, their respective attending physician will be the ordering physician ..." CDC guidance, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", dated 9/10/21, indicated, "Evaluate Residents at least Daily: Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection. Actively monitor all residents upon admission and at least daily for fever (temperature 100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry ... Older adults with SARS-CoV-2 infection may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for SARS-CoV-2 infection ... Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection: HCP caring for residents			

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	with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator) ... Increase monitoring of residents with suspected or confirmed SARS-CoV-2 infection, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infection." 2. On 9/20/21 at 12:40 a.m., the door to Resident D's apartment was observed. A sign on the door indicated the resident was in Airborne/ Contact Precaution isolation. Throughout the facility, no other resident apartments had signage on the doors to indicate any other residents were in transmission based precaution isolation. On 9/20/21 at 2:57 p.m., a facility map was provided by the DON that indicated Residents F and G were also in isolation on transmission based precautions. On 9/21/21 at 9:45 a.m., the door to Resident G's apartment was observed. There were no signs indicating the resident was on transmission based precaution isolation. There was no PPE or hand sanitizer outside of the resident's room. On 9/21/21 at 10:02 a.m., the door to Resident F's apartment was observed. There were no signs indicating the resident was on transmission based precaution isolation. There was no PPE or hand sanitizer outside of the resident's room. During an interview on 9/21/21 at 12:33 p.m., Kitchen Aide 26 was observed as she passed Styrofoam lunch trays to residents in their rooms. She indicated, meals in the dining room had been			

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	suspended because there were three residents who were COVID-19 positive. She indicated the room numbers of the positive residents, and that she had been instructed not to deliver to those room, the nurses would it instead. At this time, Resident Tt's apartment door was observed. There was no sign posted for notification of COVID status or PPE requirements, and there was no PPE (personal Protection equipment) bin outside the door. On 9/21/21 at 11:01 a.m., policies related to transmission based precaution isolation was requested. The policies were not provided. During an interview on 9/21/21 at 2:18 p.m., the Regional Registered Nurse (Reg RN) indicated, the residents placed in isolation should have signs on their apartment doors that indicated they were in transmission based precaution isolation so that staff who cared for them would know what type of PPE to put on before they entered the resident's apartment. On 9/21/21 at 3:20 p.m., the RDO indicated, the facility followed state health department guidelines. State Department of Health Guidance, "Long-term Care COVID-19 Clinical Guidance" dated 9/7/21, indicated, "Assure that red and yellow zone is clearly marked and each resident's door has TBP [transmission based precautions] signage for proper PPE." 3. a. On 9/20/21 at 1:48 p.m., the DON indicated, she was notified on 9/13/21 that PCA 27 tested positive for COVID-19 on 9/11/21. Outbreak testing began following the facility being notified. The first testing began on 9/13/21, the second on			

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	9/17/21, and the third on 9/20/21. The DON indicated, all staff and all residents would be tested through the outbreak testing time frame, regardless of vaccination status. On 9/21/21 at 2:57 p.m., the DON provided a document and indicated it was her tracking of staff COVID-19 testing. The DON indicated all facility staff and residents should have been tested for COVID-19 three times between 9/13/21 and 9/21/21. The document indicated 8 had been tested 3 times, 7 were tested 2 times, 20 had been tested once, and 29 staff had no record of testing, out of 70 total staff. The tracking document was reviewed with the DON at that time. She indicated, if there were blank spaces on the document, it would mean that the staff member was not tested or if they were tested, it was not documented by whoever performed the test. A review of the facility schedule indicated 16 staff, with no record of COVID-19 testing during the outbreak period, had worked in the facility between 9/13/21 and 9/21/21. b. On 9/21/21 at 2:57 p.m., the DON provided a document and indicated it was her tracking of staff COVID-19 testing. She indicated the column labeled, "COVID Vaccination Status" was blank because she had not gotten around to completing the information. She was not sure which staff were vaccinated and which were not. c. During an interview on 9/20/21 at 9:56 a.m., the DON indicated PCA 27 tested positive for COVID-19. She was not sure when the staff member last worked, or what was found during contact tracing. On 9/20/21 at 1:48 p.m., information was requested			

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	from the Regional RN and DON for the most recent three COVID-19 positive staff: name and job title, copy of COVID-19 positive test result, pre-shift COVID-19 symptom screening logs for 3 shifts prior to the staff testing positive, documentation related to contact tracing, vaccination status, and proof of COVID-19 related education. On 9/21/21 at 2:24 p.m., the DON provided information related to COVID-19 positive staff: i. CNA 29 (certified nursing assistant) tested positive for COVID-19 on 9/2/21 via a rapid Antigen test (performed via nasal swab, detects certain proteins in the virus, results can be available in minutes). It was unknown if CNA 29 had any COVID symptoms. The facility did not have a copy of the COVID test result. She was unvaccinated. CNA 29 worked in the facility on 8/1/21, 8/14/21, and 8/15/21. Pre-shift COVID-19 symptom screening logs were unavailable. There was no contact tracing documentation to indicate which residents CNA 29 came in contact with or if she wore correct PPE. There was no proof of COVID-19 education available. ii. Cook 28 tested positive for COVID-19 on 9/12/21. She was unvaccinated. Cook 28 was sent home from the facility on 9/12/21 because she had symptoms of COVID-19. Documentation of what symptoms she had was unavailable. Cook 28 was tested outside of the facility. The facility did not have copy of the COVID test result. It was unknown if the COVID-19 test was a rapid test or a PCR (detects genetic material of the virus, results may be available in minutes or a few days, can be used separately or to confirm rapid test results). Cook 28 worked in the facility on 9/11/21 and 9/12/21. She worked in the kitchen making food as well as served food to the residents.			

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	Pre-shift COVID-19 symptom screening logs were unavailable. There was no contact tracing documentation to indicate which residents Cook 28 came in contact with or if she wore correct PPE. There was no proof of COVID-19 education available. iii. PCA 27 tested positive for COVID-19 on 9/11/21. She had symptoms of nasal congestion, runny nose, and fatigue. She was unvaccinated. PCA 27's duties included taking out trash from resident apartments, making resident beds, and assisting with making the staff schedule. PCA 27 last shift worked on 9/7/21. She had a close, personal contact outside of the facility that also tested positive for COVID-19. Pre-shift COVID-19 symptom screening logs were unavailable. There was no contact tracing documentation to indicate which residents PCA 27 came in contact with or if she wore correct PPE. There was no proof of COVID-19 education available. On 9/21/21 at 2:25 p.m., the DON provided a policy titled, "Guidance for Reopening Community to Visitation", dated 8/10/21. The RDO indicated, this was the facility COVID action plan, and was the policy in use by the facility at that time. The policy indicated, "During an outbreak (one case is considered an outbreak) ...complete facility-wide testing of residents and staff regardless of vaccination status (first round of testing). Test all previous negative residents and staff 3-7 days after the first round of testing and continue to test every 3-7 days until no new positives are identified for 14 days ...Communities [facilities] should maintain a record of the vaccination status of all residents and staff members and have readily available, upon demand ...The facility must use a checklist-based screening protocol ...for each person entering the facility including all staff			

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	...Thee facility must retain screening records according to the facility's record retention policy, but not for less than 30 days ...facility wide testing should be completed immediately or within 24 hours of identifying a new case of SARS-CoV-2 [COVID-19] ...For outbreak testing (identification of a new COVID-19 case in the facility): Document the date the case was identified, the date that all other residents and staff are tested, the dates that staff and residents who tested negative are retested, the results of all tests, actions the facility took based on the results ...Document if facility staff tested elsewhere: physical documentation must be obtained of who was tested, where, when, what method, etc. must be reported to the community [facility] immediately ...If there is a COVID-19 positive case detected from a direct care staff member, then initiate the process of contact tracing up to the previous 48 hours and immediately initiate Outbreak Testing Mode." CDC Guidance, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" dated 9/10/21, indicated, "Because of the risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak." CDC Guidance, "Contact Tracing for COVID-19" dated 2/25/21, indicated, "Contact tracing will be conducted for close contacts (any individual within 6 feet of an infected person for a total of 15 minutes or more) of laboratory-confirmed or probable COVID-19 patients ... Close contact evaluation and monitoring hierarchy ... PRIORITY 1: Hospitalized patients, Healthcare personnel (HCP), First responders (e.g., EMS, law			

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	enforcement, firefighters), Individuals living, working or visiting acute care, skilled nursing, mental health, and long-term care facilities ..." State Department of Health guidance, "Contact tracing helps prevent the spread of infectious disease. It means identifying people who have an infectious disease (cases) and their contacts (people who may have been exposed) and working with them to stop the spread ...people who are sick with COVID-19 can spread it to others, two days before they have any symptoms. Someone with COVID-19 can also spread it to others even without symptoms. They might not even know they have it." 4. Upon entrance to the facility on 9/20/21 at 9:35 a.m., the DON was observed in the entrance lobby, as she prepared and performed COVID-19 rapid test swabs. There were 5 unnamed residents seated in the lobby area. They were not socially distanced from each other or the DON. The DON wore a cloth face mask. She rolled her supply cart to Resident L and indicated she needed to do a COVID-19 test nasal swab. Resident L indicated she just had a swab a day ago, but the DON indicated they needed to complete swabs every other day for a while due to outbreak testing. The DON completed the nasal swab for Resident L, without donning eye protection, an isolation gown, or gloves. The DON approached a second, unnamed resident and completed a nasal swab without donning eye protection, an isolation gown, or gloves. On 9/20/21 at 9:40 a.m., the DON was interviewed. She indicated, the facility was performing outbreak testing following the positive results of facility staff and a resident. The DON indicated she was wearing a cloth face mask. She thought			

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	she could wear a cloth face mask in the facility as long as there were no COVID positive residents in the building. During an interview on 9/20/21 at 10:20 a.m., the DON indicated she wore a cloth mask in the facility because the surgical face masks made her sneeze. She indicated she knew she should not have worn a cloth face mask while in the facility. During an interview on 9/20/21 at 10:34 a.m., Resident S complained that staff refused to wear masks, particularly in the kitchen. He indicated he had complained directly to the staff and told them to wear their masks at all times, but they ignored him, so he complained to the Executive Director (ED) [who no longer worked at the facility]. The [previous] ED said he would take care of it, but nothing happened, and the staff still refused to wear their masks. Resident S indicated, "They get to go out in public to stores and what not. Who knows what they come into contact with? Even if they are vaccinated, they can still carry it. They can protect us by wearing their masks, but they don't." On 9/20/21 at 10:56 a.m., Cook 14 was observed. He stood behind the kitchen counter, at the front serving/ food preparation line. He wore a mesh beard cover, but no mask underneath as he prepared and plated lunches. During an interview on 9/20/21 at 10:58 a.m., the Dietary Manager (DM), indicated kitchen staff should wear their masks at all times, but even she pulled her mask down sometimes because it was "very hot" in the kitchen, and the masks made it hard to breath. Upon entrance to the secured Memory Care Unit			

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	on 9/20/21 at 11:03 a.m., a live music performance was heard and observed at this time. The musician played a keyboard and sang, with a face mask pulled down below his chin. There were 8 residents gathered in the common area for the activity, none wore masks or were separated by more than 6 feet. On 9/20/21 at 11:11 a.m., Hospice Health Aid (HHA) 17 was observed as she assisted Resident Pp comb his hair. She stood less than 6 feet away from him and her mask was pulled down below her nose. At this time, CNA 18 entered the room and bagged up trash from the bathroom. Her mask was observed pulled down below her mouth. On 9/20/21 at 11:17 a.m., Cook 15 was observed in the kitchen, cooking food and placing food into a service window. The food was then picked up by servers and brought directly to residents who were seated in the dining room. Cook 15 had a surgical face mask pulled to below her chin as she cooked and prepared food for the residents. During a continuous lunch observation on 9/20/21 from 11:50 a.m., until 12:15 p.m., the following was observed: Cook 15 stood behind the kitchen counter, at the front serving/preparation line. She prepared food during the entire observation with her mask pulled down below her chin. At 11:57 a.m., Kitchen Aid 20 pinched the tip of her face mask with her bare hands and pulled her mask below her mouth. She bent over, less than 6 feet away from an unnamed resident and spoke with him. She did not complete hand hygiene after she touched the outside of her mask before she handed the resident the item he requested.			

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	At 12:01 p.m., Kitchen Aid 20 pinched the tip of her face mask with her bare hands to pull her mask down, then back up, as she spoke to Cook 15 through the window. Kitchen Aid 20 did not perform hand hygiene after she touched the outside of her mask, before she served a plate to Resident T. At 12:07 p.m., Cook 15 exited the kitchen as she carried a large, clear, uncovered plastic bin with food inside to restock the front reach-in refrigerator. She carried the bin below her stomach, pressed against her body, so that the bottom of her lose shirt, hung just inside the rim of the plastic bin that contained food items. At 12:10 p.m., Resident H entered the dining room. She sat at a table, put her hand up into the air and motioned toward the Dietary Manager (DM). Resident H indicated out loud, across the dining room, "[Cook 15] still doesn't have her mask up!" During an interview on 9/20/21 at 12:11 p.m., Resident H indicated, it had been an ongoing problem that staff would not wear their masks. She had talked to the Executive Director about her complaint, but nothing changed. Resident H indicated, "I know they are hot [wearing a mask], and I'm sorry for that, but this is our health!" At 12:13 p.m., Cook 15 was observed as she ran her finger along the bottom of her nose, as if to itch her nose. She did not perform hand hygiene but continued to prepare lunch plates for the residents. During an interview on 9/20/21 at 12:15 p.m., the DM indicated, it was "too hot" in the kitchen to wear a face mask. That was why Cook 15's mask			

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	was pulled down. The DM indicated she had been told that while they were in the kitchen, the staff were allowed to pull their masks down. The DM had complained for a long time that the AC unit in the kitchen did not work well, and they needed better ventilation, but nothing had been done about it so she let her staff pull their face masks down. On 9/21/21 at 12:28 p.m., Cook 15 was observed behind the kitchen counter, at the front serving/preparation line. She prepared food with her mask pulled down below her chin. On 9/21/21 at 9:00 a.m., a record review was completed for Resident H. Resident H had current diagnoses which included, but were not limited to, chronic kidney disease, congestive heart failure, and Diabetes mellitus. She had been vaccinated for COVID-19 on 2/18/21. A nursing progress note, dated 9/21/21 at 10:00 a.m., indicated Resident H tested positive for COVID-19 and had symptoms of a runny nose and body aches. A review of the CDC (Centers for Disease Control) website (https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html) on 9/21/21 at 9:15 a.m., indicated, "Older adults are more likely to get severely ill from COVID-19. More than 80% of COVID-19 deaths occur in people over age 65, and more than 95% of COVID-19 deaths occur in people older than 45 ... Having chronic kidney disease of any stage can make you more likely to get severely ill from COVID-19 ... Having either type 1 or type 2			

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	diabetes can make you more likely to get severely ill from COVID-19 ... Having heart conditions such as heart failure, coronary artery disease, cardiomyopathies, and possibly high blood pressure (hypertension) can make you more likely to get severely ill from COVID-19 ..." On 9/21/21 at 2:25 p.m., the DON provided a policy titled, "Guidance for Reopening Community to Visitation", dated 8/10/21. The RDO indicated, this was the facility COVID action plan, and was the policy in use by the facility at that time. The policy indicated, "Source Control refers to use of a well-fitting face covering, face masks, or respirators to cover a person's mouth and nose to prevent spread of respirator secretions when they are breathing, talking, sneezing, or coughing ...HCP [health care personnel] Source Control= surgical mask, procedure mask, or respirator ...Appropriate PPE to be worn by dining staff inclusive of medical grade mask- procedure, surgical, KN95 or N95 respirator ...When one case of SARS-CoV-2 [COVID-19] is identified in a resident or staff (outbreak), communal activities should pause until one round of facility-wide testing can be completed and the outbreak can be evaluated to determine what units are involved ...Indoor performances (vocal and instrumental) are allowed using the following guidance: Residents regardless of vaccination status must wear source control and physically distance during indoor vocal performances with singing, chanting, and reciting words or songs. Performers must wear source control and maintain physical distance 6 to 9 feet between the performer and the audience." CDC Guidance, "Guidance for SARS-CoV-2 Point-of-Care and Rapid Testing", dated 7/8/21, indicated, "Specimen Collection & Handling of			

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	Point-of-Care and Rapid Tests: Proper specimen collection and handling are critical for all COVID-19 testing, including those tests performed in point-of-care settings. A specimen that is not collected or handled correctly can lead to inaccurate or unreliable test results. For personnel collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which could include an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a lab coat or gown ... Use a new pair of gloves each time a specimen is collected from a different person. If specimens are tested in batches, also change gloves before putting a new specimen into a testing device. Doing so will help to avoid cross-contamination." CDC Guidance, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", dated 9/10/21, indicated, " ...the safest practice is for everyone in a healthcare setting to wear source control ... Source control options for HCP [health care personnel] include: A NIOSH-approved N95 or equivalent or higher-level respirator OR A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (note: these should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) OR A well-fitting facemask ... Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue,			

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	and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel) ... Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel." 5. On 9/20/21 at 11:07 a.m., CNA 18 was observed as she went in and out of several resident rooms. She gathered, and bagged up trash and dirty laundry, then set the bags outside the resident's doors. She did not wear gloves and was not observed to perform any hand hygiene before she entered, or after she exited the resident's rooms. On 9/20/21 at 2:10 p.m., Resident V was observed. He sat on a couch in the main activity area of the Memory Care Unit by himself. A smeared brown substance was observed on his right hand and fingers. A strong smell of bowel wafted from near him. At this time, QMA 22 was notified and indicated he would send CNA 23 over to assist him. CNA 23 donned gloves and approached Resident V. She reached her hand out and asked Resident V to come with her to the bathroom. She			

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	took both his hands and assisted him to stand up. As they walked through the Activity Room, Resident K stopped CNA 23 and asked her to help with the T.V. CNA 23 walked to the T.V., she did not remove her gloves, or perform hand hygiene before she touched buttons on the DVD player. She returned to Resident V, and assisted him down the hall, and into his apartment. On 9/20/21 at 2:21 p.m., CNA 23 exited Resident V's room. She carried a clear plastic bag with her bare hands. It was tied up but smeared fecal matter was visible inside the plas tic. CNA 23 indicated the resident had probably already used the bathroom but wiped poorly so she helped clean him up. She indicated the tied trash bag held fecal waste which was why she removed it from the resident's room. She walked the bag through the main activity room where several residents were seated, through the main dining room, where several more residents were seated, and threw the plastic bag away in a large blue trash can that sat uncovered in a common area hallway behind the medication administration carts. She indicated the blue trash can would be emptied when it was full. She did not perform hand hygiene after discarding the plastic bag.During a continuous, uninterrupted observation on 9/20/21 from 2:41 p.m. to 2:50 p.m., QMA 22 was observed as he prepared resident medications. QMA 22 lined more than 20 small, plastic medication cups on top of the			

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	medication administration cart. He dispensed pills from the pill administration cards and pill bottles and into the medication cups. As a cup was filled with medication, he placed the filled cup, with an empty medication cup put on top, into the top drawer of the medication cart. He dropped a pill onto the top of the medication cart, picked it up with his bare hands, and placed the pill into a medication cup. The cup was then placed in the top drawer of the medication cart. QMA 22 dropped a set of keys, that were connected to a cloth lanyard, onto the floor. He picked up the keys by the cloth lanyard and placed them onto the top of the medication cart. He then continued to prepare resident medications. An empty cup tipped over. QMA 22 used his thumb, index, and middle finger to set the cup upright, by placing his index and middle fingers inside the empty cup and his thumb on the outside. Throughout the observation, QMA 22 did not wash his hands or use hand sanitizer.During an interview on 9/20/21 at 2:51 p.m., QMA 22 indicated, there was no hand sanitizer on the medication cart, but he could get some from a supply closet. He should have used hand sanitizer or washed his hands before he prepared medications for the resident, and before and after touching a pill that had fallen on to the top of the medication cart. He should not have put			

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	his fingers inside a medication cup used to dispense resident medications. He should not have put his keys, which had fallen on to the floor, on top of the medication cart without first cleaning them and then washing his hands. On 9/21/21 at 11:01 a.m., policies related to hand hygiene and disposal of biohazard and/ or human waste was requested. The policies were not provided. On 9/21/21 at 2:18 p.m., the Reg RN provided a policy titled, "Medication Administration General Guidelines", dated 5/20/20. She indicated this was the current policy in use by the facility at that time. The policy indicated, "Hand hygiene is completed before and after every medication preparation or administration." CDC Guidance, "Hand Hygiene in Healthcare Settings", dated 1/8/21, indicated, " ...When and How to Perform Hand Hygiene: Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient, After touching a patient or the patient's immediate environment, After contact with blood, body fluids or contaminated surfaces, Immediately after glove removal. Wash with Soap and Water: When hands are visibly soiled, After caring for a person with known or suspected infectious diarrhea. When and How to Wear Gloves: Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other			

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		A. BUILDING 00 B. WING	09/21/2021

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	potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs ...."6. On 9/20/21 at 12:38 p.m., the state health department COVID-19 reporting system was accessed. The facility had not reported any COVID-19 positive residents or staff for September 2021. During an interview on 9/20/21 at 1:48 p.m., the Regional RN indicated the facility ED had been reporting facility COVID-19 positive results to the health department. On 9/21/21 at 11:01 a.m. the state health department COVID-19 reporting system was accessed again. The system indicated, the facility had not reported any COVID-19 positive residents or staff for September 2021. During an interview at that time, the Regional RN indicated, the ED should have			

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	reported COVID-19 testing and positive residents and staff to the health department. On 9/21/21 at 3:20 p.m., the RDO indicated, the facility followed state health department guidelines. State Health Department guidance, "LTC [long term care] Facility COVID-19 Data Submission Guidelines", dated 12/21/20, indicated licensed Assisted Living (AL) facilities were required to report a positive COVID-19 Point-of-Care (POC), a positive COVID-19 lab result (not POC), a negative COVID-19 POC result for any staff or resident within 24 hours of the result.7. During an interview on 9/20/21 at 9:56 a.m., the DON indicated there was currently one staff member (PCA 27) off working after testing positive for COVID-19. There was one resident in the facility at that time who tested positive for COVID-19 on 9/17/21.During an interview on 9/20/21 at 11:25 a.m., a family member of Residents Qq and Rr indicated they or another member of their family visited the residents in their apartment daily. They had not received any notification of COVID-19 positive staff or residents. On 9/20/21 at 1:48 p.m., the facility's mechanism for notifying residents, their representatives, and families of the COVID-19 status within the facility was requested from the Regional RN and DON. The Regional RN indicated the ED was			

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	responsible for sending the notifications. On 9/20/21 at 2:50 p.m., Resident Ss was observed in her room. A family member was present for a visit, did not have on a face mask. The family member indicated she was not aware of any new COVID-19 positive resident or staff cases in the facility.On 9/21/21 at 11:01 a.m., the facility's mechanism for notifying residents, their representatives, and families was requested again from the Regional RN and DON. The Regional RN and DON indicated outbreak testing had continued that day and at that time there were now 3 confirmed COVID-19 positive residents, and 2 confirmed COVID-19 positive staff. On 9/21/21 at 12:46 p.m., a sign in front lobby was observed. The sign indicated "Daily COVID-19 numbers Date: 9/21/21. # of staff w/ symptoms: 0; # of staff positives: 0; # of residents with symptoms: 2; # of Residents positive: 2. "On 9/21/21 at 2:18 p.m., the Regional RN indicated the facility was unable to provide a mechanism for notification. On 9/21/21 at 2:25 p.m., the DON provided a policy titled, "Guidance for Reopening Community to Visitation", dated 8/10/21. The RDO indicated, this was the facility COVID action plan, and was the policy in use by the facility at that time. The policy indicated, " ...visitors should be notified about the potential for COVID-19			

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	exposure in the facility and adhere to the core principles of COVID-19 infection prevention ...The facility then notifies residents, their families or guardians, and the long-term care ombudsman of relevant operational changes. Facilities should meet this requirement by using multiple communication channels, such as email listservs, social media, website postings, recorded telephone messages, and/ or paper notification. Facilities should post signage about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks) ...."State Department of Health Guidelines, "Changes for IDOH COVID-19 IP [infection prevention] Toolkit", dated 9/7/21, indicated, " ...the Indiana State Department of Health (ISDH) is requiring longterm care facilities (nursing facilities, skilled nursing facilities, residential facilities and assisted-living facilities) to provide to residents and their designated representatives the following: 1. How the facility is handling issues with care and staff shortages 2. General information about COVID-19 3. The number of residents and staff who have tested positive and the number of "new" positive cases (those in the last 14 days) 4. The number of residents who have died due to the virus 5. Facility mitigation actions implemented to reduce the			

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	risk of COVID-19 transmission, including if normal operations of the facility have to be altered. Communicating this information to residents and their designated representatives is critical to calming concerns and fears, as well as addressing potential misinformation. In addition, long-term care facilities must communicate facility COVID-19 status to potential residents and designated representatives prior to any admission. Long-term care facilities are also encouraged to develop COVID-19 communication strategies with other family members in addition to the resident's designated representative ... The guidelines for cumulative updates to residents, designated representatives, and families is changing from daily to weekly. In addition, anytime a confirmed COVID-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other the facility must communicate this to residents, designated representatives and families by the next calendar day."			