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	155717	A. BUILDING 00 B. WING	06/12/2021

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ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00353892, IN00353253, IN00353332, IN00352706, and IN00353045. This visit also included a COVID-19 Focused Infection Control Survey. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00353892- Substantiated. Federal deficiencies related to the allegations are cited at F684. Complaint IN00353253- Substantiated. Federal deficiencies related to the allegations are cited at F584, F689, F760. Complaint IN00353332- Substantiated. Federal deficiencies related to the allegations are cited at F689, F760, and F9999. Complaint IN00352706- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00353045- Substantiated. Federal deficiencies related to the allegations are cited at F760. Unrelated deficiencies are cited. Survey dates: June 7, 8, 9, 10, 11, and 12, 2021 Facility number: 000376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 59	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint (IN00353892, IN0035253, IN00353332 IN00352706, IN00353045 and COVID 19 Focused Infection Control Survey on June 12, 2021. Please accept this plan of correction as the provider's credible allegation of compliance. We respectfully request a desk review.	

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

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	Total: 59 Census Payor Type: Medicare: 5 Medicaid: 39 Other: 15 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 21, 2021.			
F 0584 SS=F Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;			

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	§483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to use cleaning solution to mop floors throughout the facility, ensure manufacturer's guidelines were followed related to properly mixing cleaning solution, keep clean housekeeping equipment, ensure resident dining areas were kept clean, and clear the facility's hallways of dirt and dead insects. These deficient practices had the potential to effect 59 of 59 residents residing in the facility. Findings include: On 6/7/21 at 9:45 a.m., a walk-through of the facility was completed. The resident dining room was observed to have multiple areas of moderate amounts of food debris on top of, and under multiple tables. One table, set with a race-car activity was observed to have on it a printed paper racetrack placed around table perimeter. The paper had been taped to the table, it was ripped in multiple areas, and had several dried stains of varying size, including a large area of dried with	F 0584	**Allegation - F 584 – Safe/Clean/Comfortable/Homelike Environment** It is the practice of this facility to ensure all residents reside in a homelike environment that is safe, comfortable and clean. The following policies were reviewed: 1) General Cleaning of Resident Room – Clean; 2) Hard Floor Care – Wet/Damp Mop 3) and Homelike Environment. -All residents that resident in the facility had the potential to be affected by this finding; however, no resident was affected. Housekeeping and dietary staff have been educated by the Executive Director on July 6, 2021 on the clearing and cleaning of	07/07/2021

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	brown liquid. Styrofoam bowls sat on top of the table, and contained a half-eaten jalapeno, and green beans. The menu posted on the dining room wall indicated, green beans and jalapenos were not served with breakfast that day. Also observed on the table was an empty plastic cup with a waded brown paper towel shoved into the cup, a Styrofoam cup with a peanut butter and chocolate candy wrapper placed into the cup, and blue surgical face mask discarded on the corner of table. At this time, three residents were observed eating in the dining room. On 6/7/21 at 9:58 a.m., the yellow-zone hallway (an area where residents are kept in transmission-based isolation precautions to help prevent transmission of contagious disease) was observed. The floors throughout the hall were sticky when walked upon. Licensed Practical Nurse (LPN) 3 was observed as he walked along the hallway, and into and out of several resident rooms. His shoes could be heard sticking to the floor as he walked. At the far end of the hallway, greater than 25 dead, small, winged insects were observed on the floor. During a random observation on 6/7/21 at 10:00 a.m., a mop bucket was observed in a hallway (hall 2), outside of a resident's room. The liquid in the bucket was clear, with small amounts of brown and grey discoloration. The mop bucket itself had black colored debris coating the inside, bottom of the bucket. The discoloration and debris extended up sides of the bucket and could be seen in thick layers in the bucket's crevices. The mop wring-out component had the same black debris and discoloration covering the majority of its surface. On 6/7/21 at 10:03 a.m., the Housekeeping Supervisor (Supervisor 6) and Housekeeper 7		dining tables after meals and sweeping and mopping of floors in dining rooms. The clearing and cleaning of tables and floors will be monitored by the Executive Director, DON , ADON or designee 5 x a week for 4 weeks; 4 x week for 4 weeks; 3 x a week for4 weeks; 2 x a week for 4 weeks and 1 x weekly for 8 weeks. Any concerns noted during the audits will be addressed immediately and any patterns identified in QA will be presented to the QAPI committee. QAPI committee will then write an action plan. Mop buckets and wringers were replaced. Housekeeping staff was educated on the cleaning of floors, use of floor cleaner and how to test chemical and on maintaining their equipment. This will be monitored by the Executive Director, DON, ADON or designee 5 x a week for 4 weeks; 4 x week for 4 weeks; 3 x a week for4 weeks; 2 x a week for 4 weeks and 1 x weekly for 8 weeks. Any concerns noted during the audits will be addressed immediately and any patterns identified in QA will be presented to the QAPI committee. QAPI committee will then write an action plan.	

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	were interviewed. Supervisor 6 indicated the facility was waiting for a shipment of the disinfectant cleaner usually used throughout the facility. Housekeeper 7 indicated housekeeping staff were mopping the floors with water. Supervisor 6 indicated the floors throughout the facility were sticky, so housekeeping staff had been mopping with water to hopefully remove the stickiness. Housekeeper 7 indicated the mop bucket observed contained only water. No cleaning solution was in the mop bucket at that time. During an interview on 6/7/21 at 10:08 am, a Floor Technician (floor tech 4), was observed mopping on the hallways of the secured memory care unit. He indicated he was not sure what he was mopping the floors with. He thought it was just water. During a random observation on 6/7/21 at 2:42 p.m., Resident Y and Z's was observed from the hallway. Through the open door of the residents' room, a puddle of liquid was observed on the floor in front of a large, double-door, wardrobe. The liquid extended out into the room greater than 1 foot from bottom of wardrobe and spread out greater than 2 feet across bottom of wardrobe. Both residents were observed laying down in their respective beds. On 6/7/21 at 2:48 p.m., the yellow-zone hall was observed a second time. The greater than 25 dead, small, winged insects observed earlier in the day were still present on the floor at that time. On 6/8/21 at 8:37 a.m., the yellow-zone hall was observed for a third time. The greater than 25 dead, small, winged insects observed twice the day before were still present on the floor at that			

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	time. On 6/8/21 at 8:49 a.m., Floor Tech 4 was observed mopping the entrance to hall 2. He indicated he was mopping with water. On 6/8/21 at 8:55 a.m., the resident dining room was observed for a second time. The stained, ripped, paper racetrack table still had the same debris as noted the day before. Additional items were observed on the table at this time which included, more than 5 used Styrofoam cups, a Styrofoam bowl of half-eaten food, and a crumpled blue surgical mask. Several tables in the dining room were noted to have food debris and/ or liquid on top of and underneath several tables. At this time, 5 residents were observed sitting in the dining room eating. A third observation of the dining room on 6/8/21 at 1:37 p.m. The paper racetrack table was observed with the same dirty, wet, torn paper racetrack taped to the tabletop. A single point cane with the label "physical therapy" laid on floor next to the table. A fleece scarf was observed draped over a chair at the table. A Styrofoam cup greater than halfway full of dark liquid, which resembled coffee sat on top of the table. On 6/8/21 at 1:40 p.m., a long, metal-topped, storage cabinet was observed in the resident dining room. A water dispenser was on top of the cabinet and observed to be coated in a thick white/ yellowish substance. From the water dispenser nozzle hung a greater than half an inch long white/ brown/ yellow substance, with a water drip noted at the end of the hanging substance. Underneath the cabinet, the floor was coated with thick, black debris, and food debris items of			

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	varying size and age. At this time, 4 residents were observed in the dining room eating. On 6/8/21 at 1:45 p.m., hall 2 was observed. A mop bucket was placed in the hall, outside of a resident room. Inside the mop bucket was cloudy water. The mop bucket and mop wringing component had several areas of thick, black discoloration throughout its surfaces. During an interview on 6/8/21 at 1:47 p.m., with Housekeeper 7 she indicated she was not given any cleaner that day to mop the floors. She had been instructed to mop the floors with water. On 6/9/21 at 8:59 a.m., Supervisor 6 was observed, inside the housekeeping closet, as he filled a mop bucket with water. During an interview at this time, he indicated the shipment of disinfectant cleaner had arrived. When asked how much cleaning chemical had been put into the mop bucket with the water, Supervisor 6 took a spray bottle labeled [disinfectant cleaner] from the top of the housekeeping cart, unscrewed the lid, and poured an unmeasured amount of pink liquid from the cleaner spray bottle into the mop bucket. Supervisor 6 indicated the housekeepers just dumped some of the cleaner from the spray bottles into the mop bucket water. He could tell how much cleaner to add by the color of the mop water. He indicated the cleaner had to be diluted because it was very potent and would not be safe to use around residents in its full strength. On 6/9/21 at 10:50 a.m., Housekeeper 7 was observed as she mopped in the lobby, in front of public restroom doors. She indicated the facility got a shipment of the cleaner that day, so she was no longer mopping with just water.			

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	During an interview on 6/10/21 at 11:47 a.m., with Supervisor 6, he indicated [disinfectant cleaner] was used for all surfaces, throughout the facility to include resident rooms, and floors. Supervisor 6 indicated the disinfectant cleaner's kill time (or contact time, the time it takes for a disinfectant to kill the bacteria or virus it claims to be effective against) was 10 minutes. The spray bottles are filled with cleaner, from a wall-hung, chemical dispenser. Supervisor 6 indicated he poured some chemical in the bottle and then cut it with enough water, so it was the "right color." The cleaner was poured from the spray bottle into the mop bucket. He could tell by the color of the water when the cleaner was mixed in, that it was the right amount of cleaner. He indicated he did not use chemical testing strips to check the concentration of the spray bottles or the mop water. He was unfamiliar with what the testing strips were or how they would be used. Supervisor 6 indicated the housekeeping staff also used single-use floor mopping pads when they cleaned the floors in the residents' rooms. The housekeeper sprayed some cleaner sprayed on the pad and took it to the floor. The housekeeping staff currently mopped with water because the disinfectant cleaner was making the floor sticky. Housekeepers cleaned the floor with the disinfectant cleaner first, then went over the floor with plain water, and let the floor air dry. He indicated this was the practice being used throughout the facility, and in residents' rooms, at that time. An undated policy titled, "General Cleaning Policies and Procedures Resident Room - Clean" was provided by the administrator on 6/9/21 at 8:40 a.m. The administrator indicated this was the current policy used by the facility at that time. The policy indicated, "Purpose: To provide a clean, attractive and safe environment for residents,			

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	visitors and staff ... 15. Wet Mop the Resident Room and Bathroom Floors: ...b. Immerse the mop in the bucket of disinfectant cleaner and wring it out. You want the mop wet enough to allow the disinfectant cleaner to "dwell" on the floor. This will allow the disinfectant to work ...." An undated policy titled, "Hard Floor Care Policies and Procedures Hard Floor - Wet/ Damp Mop, Clean/ Disinfect" was provided by the Director of Nursing (DON) on 6/9/21 at 3:45 p.m. The DON indicated this was the current policy used by the facility at that time. The policy indicated, "Floor cleaner [disinfectant cleaner name]- follow manufacturer's guidelines ...." On 6/11/21 at 11:38 a.m., the disinfectant manufacturer information was reviewed. The manufacturer's guidelines indicated, "Preparation of Use-Solution: Mix ½ to 1 oz [ounce] per gallon of water. For heavy duty use, mix 2 oz. per gallon of water ...Apply use-solution to hard, non-porous (without holes) surfaces ...Treated areas must remain wet for 10 minutes ...." An undated policy titled, "Homelike Environment" was provided by the administrator on 6/11/21 at 5:19 p.m. The administrator indicated this was the current policy used by the facility at that time. The policy indicated, "It is the policy of the facility to ensure that the environment provided by the facility is safe, sanitary, and comfortable ...." This Federal tag relates to Complaint IN00353253. 3.1-18(a) 3.1-19(f)			
F 0678 SS=J	483.24(a)(3) Cardio-Pulmonary Resuscitation (CPR)			

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Bldg. 00	§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. Based on observation, interview, and record review, the facility failed to ensure residents choice of code status was documented in the medical record for 5 of 59 residents reviewed for advanced directives (Resident D, W, M, BC and N) which resulted in immediate jeopardy when the facility failed to follow the Cardiopulmonary Resuscitation (CPR) procedure for an unresponsive resident without respirations and no code status recorded resulting in death (Resident D). The Immediate Jeopardy began on 6/7/21 when Resident D was found unresponsive, and the nurse was unable to determine the resident's code status from the medical record. The nurse left the resident unattended and called the hospice company and the Director of Nursing (DON) for guidance. The DON indicated the resident was a full code and to initiate CPR. The nurse took the Code Cart to the resident's room but failed to initiate CPR or call 911, when she took a call from hospice and during the conversation determined the Resident was a DNR. CPR was not initiated. No DNR paperwork was signed so the resident should have been a Full Code. The Interim Administrator, Director of Nursing, Regional Director of Operations, and Regional Nurse Consultant were notified of the immediate jeopardy on 6/9/21 at 5:47 p.m. The immediate jeopardy was removed on 6/11/21, but noncompliance remained at a lower scope and severity of isolated no actual harm with potential for more than minimal harm that is not immediate	F 0678	**Allegation—F-678—Cardio-Pul monary Resuscitation (CPR)** Facility failed to ensure that a resident's choice of code status was documented in the medical record and the staff failed to perform CPR for a resident found unresponsive without a documented code status resulting in the death of Resident D. Hospice met with the resident to determine the resident's preference, but the resident was not cognitively able to make that decision. Before a code status was obtained, the resident was found unresponsive on 6/7/21. Staff did not start CPR. When the resident was found, calls to the DON and HOSPICE were made to determine if CPR should be started. Staff failed to initiate CPR at all and the resident died. All residents should be reviewed to see that their preferences for code status is documented. Staff need education on the procedure for unresponsive residents without code status, and education on CPR. **Resident(s) Affected—What corrective actions will be accomplished for those resident)s) found to have been**	07/07/2021

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	jeopardy. Findings include: On 6/7/21 at 9:39 a.m., during a random observation of the 100 Hall, Resident D was observed sitting in a wheelchair in his room, with an overbed table in front of him. A breakfast meal tray was on the table, in front of the resident. He was eating. On 6/7/21 at 3:00 p.m., Resident D's medical record was reviewed. The resident had been admitted to the facility on 6/1/21. The diagnoses included, but were not limited to, pneumonia, bladder cancer, and abdominal pain. The demographics bar of the electronic record did not list a code status. There was no code status listed in the physician's orders. A General Progress Note, dated 6/1/21 at 11:31 p.m., indicated, "resident arrived via stretcher. He is alert and able to voice his wants and needs. Staff assisted him to and from the bathroom. medications inputted and pharmacy notified. Resident continues on pain medication. Called [sic] placed to [Company Name] hospice to let them know that he is here. He will be hospice during his stay. He has Bladder Cancer and has no options at this time. Staff continues to assist him as needed. Will continue to follow up as needed." A Hospice Care Plan, dated 6/2/21, with a target date of 8/31/21 indicated Resident D received hospice services from [Name of Company] Hospice. The goal indicated Resident D's wishes for hospice services would be respected thru the		**affected by the deficient practice-** Resident D expired. **How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken—** Residents who reside in the facility have the potential to be affected by this finding. A facility-wide audit was completed by licensed nurses to ensure that all residents residing in the facility have clearly documented preferences, (their preference, or if they have a responsible party or a guardian in place due to cognition issues, their direction), as to the code status of each resident. Further, all residents who have DNR, (Do Not Resuscitate), as their preference—have a POST FORM in place. As part of the admission/re-admission process, the CPR status of admitted/re-admitted residents will be obtained. In the event of a delay for whatever reason, of being able to obtain the preference for CPR status of a resident, CPR will be administered. At the daily, Monday through Friday CQI morning clinical meetings, any newly admitted or re-admitted residents since the prior CQI morning meeting will have their	

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	next review date. The interventions included educate family/resident as needed on the end of life care process. Hospice services as ordered. Invite Hospice to all care plan meetings. Keep hospice CNA/nurse updated on any care changes. Keep hospice notified of all transfers and discharges. Notify Hospice nurse of any new orders and changes in condition. Observe for pain. On 6/7/21 at 9:31 p.m., a Nursing Progress Note indicated, "Resident found laying [sic] in the bed[sic] with a change in skin tone, non-responsive to physical touch and sound, respirations 0, Spo2 [oxygen saturation] 10%, HR [heart rate] 0, BP [blood pressure] 0/0 .MD [medical doctor], Family, nursing management, hospice notified. Notification of death permit completed; body picked up by [Name] funeral home in [City Name]." On 6/7/21 at 10:32 p.m., an Advance Directive Discussion (Admission) form was initiated in the patient care record. It was blank, never completed. The status shows "in progress." During an interview, on 6/8/21 at 9:42 a.m., the Director of Nursing (DON) indicated Resident D had passed away last night, it was expected. He was hospice. He was young. The doctor said had he been treated when he was first diagnosed, they could have cured him, but he was too far advanced. He was a do not resuscitate (DNR). He did yell out a lot, his pain probably was not controlled. On 6/9/21 at 9:08 a.m., Resident D's paper chart and hospice admission booklet were reviewed. The admission booklet appeared to be questions and answers related to the company and hospice		CPR status reviewed and discussed. The SSD will spearhead ensuring that the CPR status is obtained. This status will be followed up on daily in the CQI morning meetings as part of the agenda daily, until the CPR status is clear for any admitted or re-admitted resident. The code status will be located under the CODE STATUS tab in the medical record. The code status will be reviewed at the care plan meetings. The DON/ADON/SSD will review all code status determinations weekly x 3 months. Any concerns will be addressed if found. The CPR audit tool will be used for these audits. After that, CPR status determinations will be reviewed monthly x 6 months. Any concerns will be addressed if found. Afterwards, monthly audits will continue by the SSD ongoing. Any concerns will be addressed if found. A member of the Regional Team will review CPR status for residents weekly x 3 months as oversight monitoring. Any concerns will be addressed if found. Further, an audit was conducted by licensed nurses to define which staff were CPR certified. All	

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	care. It did not contain any advanced directives or code status information. The resident's face sheet was blank in the area which indicated code status. The face sheet indicated Resident was his own responsible party. The advanced directive section tab in the hard chart contained nothing. On 6/9/21 at 10:55 a.m., during an interview, the DON indicated the DNR- post form should have been in the front of the chart, clearly visible and ready for staff to be able to check. Resident D did not have a post form in his chart. Licensed Practical Nurse 21 had called hospice, on the phone and asked his code status, when they found him blue in the bed. Hospice told them not to attempt resuscitation. The documentation was not in his record. The DON called hospice and asked them to fax over the documentation for his DNR, at that time, but they were still waiting for it. On 6/9/21 at 3:13 p.m., during an interview LPN 21, indicated she had usually worked evening and night shifts. She usually worked the 100 hall and was familiar with Resident D. He had been admitted to the facility due to bladder cancer and was receiving hospice services. The hospice had done admission paperwork for him on Wednesday (6/2/21). She had received report from day shift that nothing was unusual, he was "OK." She gave him his 4:00 p.m. medications and he had asked for lorazepam (anxiety medication) and when smoke time was. She said she would check on him after she finished medication pass. The CNA came and told her he had a fall, when she went down to check on him, and he was already back in bed. She didn't know if he put himself back in bed, but he was capable of doing so. She initiated vital signs, and neuro checks. They were all within normal limits (WNL). He just didn't say anything about the fall just worried about smoking. No new		nurses will be required to have current and valid CPR certification to ensure that there is always a certified in CPR nurse on duty. Any nurses who do not have a current CPR certification will be assisted by the facility to get this in place in their personnel files. Going forward, newly hired nurses will be required to either have a current CPR certification, or to be in process of getting the certification. The facility will assist as necessary. The files of nurses will be audited monthly by the DON/ADON/HR to ensure that nurses are CPR certified, or are in the process of being CPR certified. The facility will assist as necessary. This process will be ongoing. A member of the Regional Team will review the CPR status of the facility nurses monthly x 3 to ensure ongoing compliance. Any concerns will be addressed if found. **Training** **What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur---** At an in-service held for nursing staff beginning 6/9/21, conducted by the Director of Nursing, the following was reviewed/discussed: 1) Resident Rights	

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	injuries, he had some previous areas. She "guessed" he had a lot of edema, where he had been weeping and then some area opened on bilateral lower extremities. The fall was unwitnessed, so we assumed he hit head that's why neuro checks were initiated. On the next 15 minutes check, still asking when it was time to go smoke, but at that time it was dinner time, so she moved the tray to him. Dinner was already in the room. When she came back, still checking on him for fall follow up, he had eaten a little bit of the hot dog all of the fruit and all of his juice. Did not go out to go smoke. Then she came back to check, he was still eating slow, then he stopped asking about smoking and he was just eating really slow, which was his usual, she told him she would take him out to smoke later. He had 2 falls. One before dinner and one after dinner. She went back to continue neuro checks, this time he was on the floor, right in front of his bed, laying on his right side facing the door, his eyes were closed. He was non-responsive to verbal stimuli, he just looked lifeless, his color hadn't changed it was still kind of pink, and his eyes were closed. She flipped him onto his back and shook him, but he still did not respond. She did a sternal rub, but no response. She thought he was a hospice resident and had to look for a code status. There was no code status documented so she called the DON and hospice to determine the resident was a DNR. She could not remember the timeline exactly, just that there was a fall before dinner, and a fall after dinner. The dinner tray had already been picked up, before the second fall. Dinner was about 5:30 p.m. Hospice had given a booklet to her on Wednesday before they left, after they had completed the admission. It was a bound booklet and she put it on his chart binder. It did not contain any orders or code status.		1) CPR status—What is it? When should it be known? Who decides it? When is CPR done? Who does it? 2) Where is CPR status found in the medical record? 3) What is a POST FORM? Who needs one? 4) What if a code status is not in place and a resident becomes unresponsive? What is done? 5) Questions/Answers—Discussion Knowledge was measured by use of a “post test”. A score of 100% for correct responses will be required to pass. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined. Nursing staff will not work until they receive the in-servicing and pass the post-test in this AOC. **Monitoring—** **How the corrective action will be monitored to ensure the deficient practice does not occur—i.e., what quality assurance program will be put into place and by what date the systemic changes for each deficiency will be completed—** The monitoring/audits by the DON/ADON/SSD as to code status for the residents will be presented at the weekly, then	

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	On 6/9/21 at 3:40 p.m., during an interview the DON indicated when LPN 21 called her she was driving in her car. Her first thing was to always say, we don't have code status, start CPR. LPN 21 grabbed the crash cart. She pulled over into a parking lot to check the medical record and couldn't find anything, so told her to start CPR. On 6/9/21 at 3:57 p.m., LPN 21 indicated when the DON spoke to her on the phone, she did not tell her to initiate CPR, she did get the crash cart and was putting the oxygen on him, but that's when hospice called her back and told her he was a DNR. She never made any compressions. She was the one who found him, he was still warm, the last time she would have laid eyes on him would have been no more than 30 minutes prior because of the neuro check follow ups. She remembered waiting for that open window so she could get other stuff done. On 6/9/21 at 4:32 p.m., during a telephone interview, the [Name of Company] Hospice Director indicated the Hospice Admission Nurse had completed the hospice admission assessment, for Resident D, in the facility on 6/2/21. Any signed paperwork had not been returned to facility, he passed away before the next hospice visit, so his chart did not contain all the forms. The Hospice Admission Nurse would have printed the forms out when she returned to the office. Then the physician would have signed off on the orders, and the forms would have been returned to the facility at the next visit. When the Hospice Admission Nurse completed the assessment, for Resident D, she talked to the resident about his advanced directive, but she did not feel he was mentally able to make a commitment or sign anything, at that time. The facility had been informed by the Hospice Nurse,		monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored weekly by the administrator until resolution. Additionally, the monitoring/audits by the DON/ADON/HR as to nursing staff who are CPR certified will be presented at the weekly, then monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored weekly by the administrator until resolution. The monitoring by the Regional Team member will also be presented at the weekly, then monthly QAPI meetings for review and discussion. A member of the Regional Team will attend the weekly, then monthly QAPI meetings for a period of 3 months either in person or remotely to ensure ongoing compliance. Note: An Ad Hoc QAPI meeting was held 6/10/21 to discuss the AOC and how it is to be rolled out	

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	when she was leaving and gave them the bound hospice information guide, he would be a full code, because they had nothing in writing to make him a DNR. Hospice had spoken to his sister, who thought he had that in writing at one time, but she did not have a copy of it. (Name of Hospital), where he came from, had nothing signed in writing for him to be a DNR, even though they had referred him for hospice and comfort care. So, until they could get a post form signed, legally he had to be a full code. The Hospice Director had talked to the DON yesterday about the resident and told her he should have been a full code. It was her understanding he was coded at the time he was found unresponsive. On 6/9/21 at 1:12 p.m., the Assistant Director of Nursing provided a current, undated policy, titled, "Advance Directives Policy and Procedure." This policy indicated " ...Determine on admission whether the resident/legal representative has a advanced directive and if not, determine whether the resident/legal representative wishes to formulate an advance directive ...Establish mechanisms for documenting and communicating resident choices to the IDT [intradisciplinary team] ...Upon admission the facility will provide written information to the resident/legal representative concerning the resident's rights to make decisions regarding medical care including the right to accept/refuse medical treatment and the right to formulate advance directives ...Upon admission, the facility must determine if the resident executed an advance directive or has given other instructions to indicate what care is desired in case of subsequent incapacity ...." The immediate jeopardy that began on 6/7/21 was removed on 6/11/21 when the facility assessed all residents for code status. Residents with DNR		and implemented. The IDT, (Interdisciplinary Team), attended the meeting with Regional Team members and the Medical Director.	

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	were reviewed for signed post forms. Nursing staff were in-serviced on CPR and code status. The facility initiated a plan to ensure residents admitted to the facility had documented code status. The noncompliance remained at the lower scope and severity level of isolated no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. 3.1-37(a)			
F 0684 SS=J Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident had a complete assessment after a fall and changes in condition and was sent out of the facility for treatment to the emergency room in when ordered by the physician for 1 of 4 residents reviewed for falls (Resident C). This resulted in immediate jeopardy when Resident C experienced a delay in treatment for injuries and was in hypovolemic shock (life-threatening condition with loss of 20% of blood or body fluids), acute kidney injury, and had right upper quadrant tenderness when arrived at the hospital. The Immediate Jeopardy began on 5/5/21 at 6:40 a.m., when a Resident C had an unwitnessed,	F 0684	We believe the citation should be removed or at a lesser scope and severity due to factual information that the facility had and was available at the time of the survey. **Allegation—F-684—Quality of Care** The facility failed to follow the physician order to send a resident on blood thinners complaining of abdominal pain, and with altered mental status after a fall, to the ER, causing a delay in treatment for a resident whose fall resulted in the resident presenting at the hospital in shock with anemia and	07/07/2021

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	undocumented fall. The record lacked documentation of a complete set of assessments by not recording blood pressures for 7 of 9 assessments and the neuro checks ended at 11:00 a.m. Initial communication with the physician recorded at 6:40 a.m. gave instructions to send the resident to the emergency room (ER). The record lacked documentation of what time the resident left the facility, but an ER document indicated the first blood draws in the ER were at 3:49 p.m., more than 9 hours later. At that time, Resident D was medically unstable in critical condition and required immediate life-saving intervention due to hypovolemic shock with low hemoglobin, acute kidney injury, and right upper quadrant tenderness. The Interim Administrator, Director of Nursing, Regional Director of Operations, and Regional Nurse Consultant were notified of the immediate jeopardy on 6/10/21 at 2:59 p.m. The immediate jeopardy was removed on 6/12/21, but noncompliance remained at a lower scope and severity of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: On 6/7/21 at 11:27 a.m., Resident C's record was reviewed. The record indicated had diagnoses that included but were not limited to signs and symptoms involving cognitive functions and awareness, dementia with behavioral disturbance, prosthetic (artificial) heart valve, paroxysmal (situated near the center) atrial fibrillation, dysphagia (deficiency in generation of speech), oropharyngeal phase, and cognitive communication deficit. Resident C's mental status was listed as severely impaired. A nursing progress note, dated 5/5/21 at 6:40 a.m.,		hypotension requiring 2 units of blood and dobutamine, acute kidney injury and a rib fracture for 1 of 4 residents reviewed for falls. (Resident C) Resident C had an unwitnessed fall on 5/5/21 at 6:40 a.m. resulting in the resident complaining of abdominal pain. The physician was called and requested the resident be sent to the ER. Family was called and agreed to resident going to the hospital to have radiology tests due to high risk of bleeding with blood thinners. Non-emergent transportation was called instead of 911. Resident arrived to hospital triage around 3:30 p.m. When the resident arrived at the hospital he was in shock and hypotensive requiring 1 unit of blood ad dobutamine to raise his blood pressure into the 80's. Resident had a right rib fracture and acute kidney injury. The facility needs to ensure that residents in need of acute care receive immediate assessment and transfer. Staff needs to be in-serviced on fall procedure, call for transportation and following physician orders. **Resident Affected—** **What corrective actions will be accomplished for those residents found to have been affected by the deficient**	

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	indicated the Director of Nursing (DON) completed an SBAR (communication technique with physicians: situation, background, assessment, recommendation). The SBAR indicated Resident C experienced a change in condition with altered mental status and uncontrolled pain in his abdomen after an unwitnessed fall. A nursing evaluation was completed and indicated Resident C was more forgetful, had a change in consciousness and used a Coumadin (a blood thinning medication). A new order was given by the physician to send the resident to the ER for further evaluation after the fall. On 5/5/21 at 8:02 a.m., a note text by Registered Nurse (RN) 26 indicated, the Certified Nursing Assistant (CNA) alerted the RN at 6:40 a.m. that Resident C had fallen. The resident was found lying on floor with 1/3 of his body under the bed. He was in a supine position. He was assessed and was found neurologically intact. He was assisted back to bed with no apparent injury. The resident was alert to his name only. She contacted the DON and the family about the resident's fall. The family member indicated he wanted the resident to get an MRI of his head. On 5/5/21 at 12:07 p.m., a note text by Licensed Practical Nurse (LPN) 11 indicated, "resident was sent to (name of hospital) for MRI that (name of family member) had requested resident is on coumadin therapy therapy [sic] spoke with ER nurse concerning basis line change in mental status (mention has been declining in his cognition over the last 2 weeks)...." The Medication Administration Record (MAR) indicated on 5/5/21 at 3:00 p.m. Resident C's pain level was 6 (out of 10).		**practice—** Resident C is still a patient at the VA hospital. **How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken—** Residents who reside in the facility have the potential to be affected by this finding. A 60 day “look back” of all progress notes for all residents residing in the facility was completed in an effort to ensure no other resident had presented with a change in mental status that was not addressed, or a fall that was not followed up on timely to include appropriate assessments being completed and timely transfers (if indicated), having occurred. There were no findings. Further, any MDS significant change (over the past 60 days), was reviewed to ensure that appropriate assessments were completed and that no altered mental status or pain was present and not followed up on appropriately and timely. There were no findings. Additionally, the mental health provider’s notes were reviewed to ensure that any altered mental status was assessed and addressed timely. There were no findings. Going forward, the DON/ADON will be notified immediately of any	

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	On 5/5/21 at 8:04 p.m., during a (name of company) Telehealth Visit with Nurse Practitioner (NP) 25. "The nursing staff reports resident had a fall this morning at 0630, unwitnessed, have noticed increased confusion. Family is concerned he may have hit his head due to changed mental status with an unwitnessed fall and the recommendation to send resident to ED. This plan and any patient orders were given verbally to (name of staff member) LPN 11." Physician's orders included, but were not limited to, a. Warfarin Sodium (blood thinner, coumadin) tablet 4 mg, give 8 mg by mouth one time a day related to paroxysmal atrial fibrillation, ordered 4/21/21. b. Send resident to ER for MRI for head injury, increased confusion x 2 weeks, ordered on 5/5/21 at 12:37 p.m. A document for Resident C titled, "Change in Condition Evaluation," dated 5/5/21, was provided by the DON on 6/8/21 at 2:29 p.m. A review of the document indicated, Resident C had altered mental status and uncontrolled pain. There was a gradual change in level of consciousness. The physician was notified on 5/5/21 at 3:00 p.m. with recommendations to send to the ER. The most recent blood pressure was 170/80 on 5/5/21 at 12:32 p.m. There was an abdominal/GI assessment change in condition and the resident reported abdominal pain. The resident was on coumadin. Since the change in condition occurred the symptoms or signs had gotten worse, and the resident should be sent to hospital. The hospital indicated he was in hemolytic shock, and blood was too low.		falls. The DON/ADON will assist in decision making as to whether or not the resident should be sent out 911 for follow up on the fall. And, that all required notification are be made. The resident's post fall—Fall Assessment as well as their post fall Pain Assessment will be discussed. Further, the resident's meds will be reviewed. If the resident is on a blood thinner and is complaining of post fall pain, and/or has altered mental status—the resident will be sent to the ER via 911. Additionally, if the physician orders for the resident to go to the ER, 911 will be called for the immediate transport of the resident. This fall review with the facility and the DON/ADON will be ongoing on all falls for a period of at least 6 months. The falls will still be reviewed at the next daily CQI morning meeting Monday through Friday as a "second check" of all falls by the IDT, (Interdisciplinary Team). Therapy will follow-up on all falls to see if a screen and possible addition to caseload is appropriate. A Regional Team member will review falls either remotely or via discussion with the DON/ADON weekly to ensure that those that resulted in pain, and/or altered mental status and were incurred by a resident on a blood thinner,	

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	An untitled worksheet for neuro checks for Resident C was provided by the DON on 6/8/21 at 2:29 p.m. Resident C's neuro checks started after a fall on 5/5/21 at 6:40 a.m. and continued until the 11:00 a.m. neuro check. His blood pressure was not recorded according to the facility's policy on 5/5/21 at 6:40 a.m., 6:55 a.m., 7:10 a.m., 7:25 a.m., 7:50 a.m., 8:20 a.m., and 9:00 a.m. The neuro check document ended at 11:00 a.m., Resident C did not arrive at the emergency room until approximately 3:30 p.m. During an interview, on 6/9/21 at 3:00 p.m., the DON indicated for neuro checks, the blood pressure should have been assessed to complete assessments according to the policy. During an interview, on 6/9/21 at 3:53 p.m., the DON indicated if Resident C's physician said send the resident to the emergency room, then staff should have called 911. She did not know why the resident wasn't taken to the emergency room by 911 or why the resident was at the facility for hours after the physician indicated to send the resident to the emergency room. It would not take 9 hours for a 911 ambulance to show up. After Resident C arrived at the hospital the DON was told Residents C was internally bleeding and his blood sugar was low. No explanation for the differences in documented times of physician notification in the resident's record was provided. (Name of Hospital) provided documents on 6/10/21 at 11:44 a.m. An emergency room (ER) physician's report, dated 5/5/21 at 3:49 p.m., completed upon Resident C's arrival to the ER indicated Resident C arrived at the emergency room via ambulance, after nursing facility staff found him on the floor at 6:40 a.m. The report indicated facility staff told the hospital staff,		were sent out for evaluation and treatment via 911. This oversight will continue for 3 months.	

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	"[Resident C] is not following commands like before." A RN (Registered Nurse) Emergency Department Triage (a process to determine the severity of a condition) note, dated 5/5/21 at 4:01 p.m., indicated Resident C was brought to the ER for hypotension (low blood pressure), confusion, and falls. In the ER, Resident C was found to be hypotensive (low blood pressure) with SBP (systolic blood pressure, a measurement of the maximum amount of blood pressure during one heartbeat, normal is 120) in the 50 - 60 range and bradycardia (slow heart rate) in the 50s (an adult normal heart rate range is 60 to 100 beats per minute). The note indicated Resident C required, "immediate life-saving interventions" due to hypovolemic shock (life-threatening condition with loss of 20% of blood or body fluid). Laboratory results, dated 5/5/21 at 3:49 p.m., indicated Resident C had a critical hemoglobin (hgb) (oxygen carrying component of a red blood cell) level of 5.8. Resident C's red blood cell (RBC) level was 3.3 (RBC levels are considered low if below 4.29). His INR (measurement of how long it takes the blood to clot) was supratherapeutic (a greater level than would actually be used in treatment) was 3.9. Resident C's acute kidney injury, measured by his eGFR (estimated kidney filtration rate), was low at 29.0 and his creatinine levels were 2.18 on admission (normal levels are below 1.2). While still in the ER, Resident C was given 2-liters (approximately 68 ounces) of intravenous (inside a vein) fluid and 1 unit of packed RBC. His heart rate and rhythm ranged from 40 to 50s, irregular and bradycardic (slow). He was started on dobutamine (an intravenous medication used to			

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	stimulate the heart muscle and improve blood flow by helping the heart pump better). At 4:35 p.m., his blood pressure increased to 81/61. Resident C was admitted to the MICU (Medical Intensive Care Unit) on 5/5/21 at 7:39 p.m. After arrival to the MICU, he received an additional 2 units of packed RBC, and 3 units of fresh frozen plasma (FFP) (the liquid portion of whole blood). A current policy, titled, "Incidents/Accidents/Falls," was provided by the DON on 6/9/21 at 10:55 a.m. A review of this policy indicated, " ...In the case of a fall, the resident will have a head to toe assessment to include a pain assessment...unwitnessed fall must have neuro checks started and continued per policy...The physician will be notified of any changes of condition related to the fall that have been identified. Orders for treatment and any interventions will be obtained...." A current policy, titled, "Change in Resident's Condition or Status," was provided by the DON on 6/9/21 at 10:55 a.m. A review of this policy indicated, " ...The nurse will notify the resident's attending physician when the resident is involved in any accident or incident that results injury including injuries of unknown origin...There is a significant change in the resident's physical, mental or psychological status...." A current policy, titled, "Neuro Checks," was provided by the DON on 6/9/21 at 1:12 p.m. A review of this policy indicated, " ...Always do neuro checks if the fall was unwitnessed by a staff member ...Notify physician and Director of Nursing/Designee with any abnormal findings immediately ...Unless ordered otherwise by the physician neuro checks are to be completed as			

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	follows: BP (blood pressure)/ Pulse/Pupil Checks (look for pupils to constrict with light) every 15 minutes for 2 hours, every 30 minutes for 2 hours, every 60 minutes for 4 hours, and vital signs and neurological checks every 8 hours and 16 hours...until 72 hours have elapsed...." The immediate jeopardy that began on 5/5/21 was removed on 6/12/21 when the facility audited all residents' records to determine if changes of condition occurred and treatment and/or notification occurred as appropriate. The staff was in-serviced on medical emergency, physician notification, and sending residents to the hospital. The facility implemented a process to monitor for timely assessments, physician notification, and transfers to the hospital. The noncompliance remained at the lower scope and severity level of isolated no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. This Federal tag relates to Complaint IN00353892. 3.1-37(a)			
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record	F 0689	We believe the citation should be	07/07/2021

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	review, the facility failed to ensure a resident's environment was safe from hazardous conditions to prevent the resident from falling, after the resident was observed in his room, by several staff members, not wearing shoes or grip socks, with multiple environmental hazards present, and screaming out loudly for several hours which resulted in an immediate jeopardy when the resident sustained 2 falls in one shift and died within hours of the last fall for 1 of 4 residents reviewed for falls (Resident D). The immediate jeopardy began on 6/7/21 when the resident's environment was observed in a hazardous condition which later that day resulted in 2 falls on the same shift, and the resident was found unresponsive on the floor, without respirations, resulting in the resident's death. The Interim Administrator, Director of Nursing, Regional Director of Operations, and Regional Nurse Consultant were notified of the immediate jeopardy on 6/9/21 at 5:47 p.m. The immediate jeopardy was removed on 6/11/21, but noncompliance remained at a lower scope and severity of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: On 6/7/21 at 9:39 a.m., during a random observation of the 100 Hall, Resident D was observed sitting in a wheelchair in his room, with an overbed table in front of him. A breakfast meal tray was on the table, in front of the resident. He was eating. The room was in disarray. A wet sheet was lying on the floor at the foot of the bed. On the floor, in front of the overbed table, was a large puddle of oatmeal. A door sign which read "yellow zone" was sticking out of the oatmeal,		removed or at a lesser scope and severity due to factual information that the facility had and was available at the time of the survey. **Allegation--F-689—Free of Accident Hazards/Supervision/Devices** Facility failed to ensure a safe and clean environment to prevent falls, ensure fall precautions were in place, and respond to a resident calling out for a resident observed in a cluttered room walking without non-skin socks and later observed calling out which resulted in immediate jeopardy when Resident D fell in the bathroom in water on the floor and died 4 hours later. Resident D was a new admission and assessed on 6/5/21, as a moderate fall risk. On 6/7/21, the resident was observed multiple times during the day, walking barefoot in his room, attempting to clean his cluttered room. The resident was observed to be calling out and staff did not respond or check on the resident. On 6/7/21, at 5:40 p.m., the resident fell in water in his bathroom when ambulating by himself barefoot. Resident D was found deceased in his room on 6/7/21 at 9:31 p.m. The facility needs to ensure all residents' rooms are free of clutter and hazards. Residents need to be assessed for fall risk and have	

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	standing up at an angle. There were multiple puddles of liquid on the floor beside the wheelchair. Plastic silverware was on the floor throughout the room in several places. On 6/7/21 at 9:47 a.m., Resident D was observed up walking around the room. He wore only gray nylon athletic shorts, no shirt, socks, or shoes. A black pair of plastic sandals were on the floor in the middle of the room. He came to the doorway and indicated he needed a broom to clean his room. He was then observed bending over scooping oatmeal up with the door sign. On 6/7/21 at 9:50 a.m., Licensed Practical Nurse (LPN) 3 went into Resident D's room. Resident D was standing on the wet sheet, which was now covered in a moderate amount of food debris. The bed and bedside table also had spilled food and debris visible from the doorway, and hall. LPN 3 asked Resident D if he was still eating breakfast. Resident D answered "No." LPN 3 removed the meal tray and dishes from the overbed table and placed it on a plastic tiered cart, in the hallway. On 6/7/21 at 11:45 a.m., while standing in the dining room, loud shrill screaming was heard, from the direction of the 100 hall. On 6/7/21 from 11:50 a.m. through 12:15 p.m., during a continuous observation, Resident D was observed sitting in a chair, by the window. He was screaming, a very shrill scream at intervals of 1 to 2 minutes, repeatedly. He would bend forward and dip his head to the floor as he screamed out. The resident continued to wear only shorts, no shirt, socks, or shoes. The room was now observed with smeared food and liquids over a large area, from in front of the door to the bed. A cup, plastic lid, a straw, 3 spoons, a fork, and 4 wadded		necessary interventions in place. Staff need educated on fall risks and fall procedure. **Resident(s) Affected—** **What corrective actions will be accomplished for those residents found to have been affected** **by the deficient practice—** Resident D expired. **How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken—** Residents who reside in the facility have the potential to be affected by this finding. All resident rooms were observed to address those with “clutter.” This clutter was organized and minimized as far as “space taking” as much as possible. Extraneous items were placed in marked containers and placed in a safe, (resident accessible with assistance), area in the facility for storage. This was done with the documented permission of the resident or responsible party—with an explanation as to the safety concern of too many items. Further, all residents had a new Falls Risk Assessment completed. At that time, care plan interventions were reviewed for appropriateness, based on the assessment findings. Additionally, any information	

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	napkins were also observed on the floor. Several unidentified employees passed up and down the hall. At 12:00 p.m., Resident D was still screaming and could be heard to the Nursing Station (10 rooms away). LPN 3 and Qualified Nurse Aid (QMA) 5 were observed at the Nurses' Station charting on computers and talking. At 12:06 p.m., an unidentified dietary aid pushed a plastic 3 tiered cart onto the 100 hallway and called out "You all's lunch trays are here." Certified Nurse Aid (CNA) 13, came out of the Nurses' Station and went to the 100 hall, where he delivered meal trays to each of the residents. Resident D continued to scream out. At 12:15 p.m., QMA 5 entered Resident D's room and closed the door. On 6/7/21 at 2:47 p.m., Resident D was observed, from the hallway, through the open door. He was sitting on the edge of the bed wearing long gray cloth pants. He was not wearing a shirt, shoes, or socks. He continued to scream out, no discernable words, just yelling out. The Screams could be heard from greater than 50 feet away in the Nurses' Station and Dining Room. Several unidentified employees passed up and down the hall without stopping to check on Resident D. On 6/7/21 at 3:00 p.m., Resident D's medical record was reviewed. The resident had been admitted to the facility on 6/1/21. The diagnoses included, but were not limited to, pneumonia, bladder cancer, and abdominal pain. The prescribed medications included, but were not limited to, hydrocodone (narcotic pain		needed to be added to the CNA reference information for their care—was updated. Residents who are to wear non-skid socks or specific footwear as an intervention for fall prevention were listed. Residents who frequently “call out” as a behavior were listed. The DON/ADON/Designee/SSD will monitor all resident rooms weekly to ensure that “clutter” is not collecting and threatening safe mobility in the room. Any concerns will be addressed if found. This monitoring will continue for 3 months. After that, monthly monitoring will continue for not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur ongoing. Any concerns will be addressed if found The DON/ADON/Designee will monitor residents who are to wear non-skid socks or specific footwear as a fall prevention intervention 5 days weekly for 4 weeks on various shifts to include some weekend shifts to ensure that this footwear is in place. After that, these residents will be monitored 3 days weekly on various shifts to include some weekend shifts to ensure that this footwear is in place. This monitoring will continue for 3 months to ensure ongoing compliance. Afterward, random monitoring will continue ongoing.	

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	medication) 5/325 milligrams (mg) give 1 tablet every 4 hours for pain, Morphine (narcotic pain medication) give 10 mg every 4 hours as needed for shortness of breath or pain last given on 6/4/21 at 10:00 p.m., and lovenox (blood thinner/anticoagulant) 40 mg inject subcutaneously (under skin) one time a day for anticoagulated. On 6/1/21 at 11:31 p.m., a General Progress Note indicated, "resident arrived via stretcher. He is alert and able to voice his wants and needs. Staff assisted him to and from the bathroom. medications inputted and pharmacy notified. Resident continues on pain medication. Called [sic] placed to [Company Name] hospice to let them know that he is here. He will be hospice during his stay. He has Bladder Cancer and has no options at this time. Staff continues to assist him as needed. Will continue to follow up as needed." A nursing care plan, dated 6/2/21 with a target date of 8/31/21, indicated Resident D had a potential for falls due to new surroundings. The goal was for no falls to have occurred. The interventions included call light in reach, coordinate care with hospice, encourage to ask for assistance with transfers or ambulation, keep paths free of clutter, and therapy screen quarterly and as needed. On 6/4/21 at 8:37 a.m., a Physician Telehealth Visit note indicated " ...Chief complaint: C/o pain to bilateral feet and finger, numbness and burning...48 year old male with bladder cancer. Resides in skilled nursing facility under hospice for symptom management. He is sitting up in chair for visit. He is anxious and asking for additional pain medications for pain to feet and fingers. He is		Any concerns will be addressed if found. Additionally, residents who “call out” will be monitored 5 days weekly for 4 weeks on various shifts to include some weekend shifts to ensure that these residents are responded to by staff. After that, these residents will be monitored 3 days weekly on various shifts to include some weekend shifts to see that these residents are responded to timely. This monitoring will continue for 3 months to ensure ongoing compliance. Afterwards, random monitoring will occur. Any concerns will be addressed if found. Note: Residents who are found to have fall prevention footwear added to their care plan, or who begin to “call out”---or new residents with these concerns—will be added to the targeted lists for: 1) Fall prevention footwear and 2) “Calling out” A member of the Regional Team will review the falls prevention interventions (clutter, wet floors footwear) weekly x 4 weeks as oversight. Plus, residents who “call out” will be monitored weekly x 4 weeks for timely staff response. Any concerns will be addressed if found. **Training—** **Training—** **What measures will be put into**	

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	taking Morphine [narcotic pain medication] concentrate and Norco [narcotic pain medication] prn [as needed] pain...." An initial fall risk assessment, dated 6/5/21, indicated Resident D's fall risk was a 9, with a score of 10 or greater being at risk. On 6/7/21 at 5:10 p.m., a fall risk assessment was entered into the electronic record, due to a significant change. The resident scored a 10 at that time. On 6/7/21 at 5:40 p.m., a nursing note indicated, "CNA reported to Nurse that PT [patient] had a unwitnessed fall, when entering to room PT was sitting in bed, he stated that had slipped in the water in bathroom, Pt didn't have on proper footing at the time of fall, Pt reported that his pain was per usual PRN [as needed] given and proven effective, slip grip socks applied, neuro checks started, no rotation or shorting of any extremities, hospice, family and management notified." On 6/7/21 at 5:10 p.m., a Change in Condition report indicated on 6/6/21 at 7:33 p.m. the resident had the following vital signs that were electronically linked from the vital signs assessed on 6/6/21. The blood pressure was 215/125, pulse 100, respirations 22. No concerns or physician recommendations were reported. On 6/7/21 at 9:31 p.m., a Nursing Progress Note indicated, "Resident found laying [sic] in the bed[sic] with a change in skin tone, non-responsive to physical touch and sound, respirations 0, Spo2 [oxygen saturation] 10%, HR 0, BP 0/0. MD, Family, nursing management, hospice notified. Notification of death permit completed; body picked up by [Name] funeral home in [City Name]."		**place and what system changes will be made to ensure that the deficient practice does not recur—** At an in-service held for all staff beginning 6/9/21, conducted by the Director of Nursing, the following was reviewed: 1) Clean/Safe/Comfortable environment—free of accident hazards/clutter—to include the danger of wet floors—and use of Wet Floor Signs 2) Resident Rights 3) Falls Policy 4) Falls Risk Assessment—Care Plans (based on Fall Assessment results) 5) CNA Assignment information related to fall prevention interventions 6) Fall Prevention Interventions—to include specific footwear 7) Residents who “call out” —as a behavior or when they need assistance—why must all such calling out be responded to timely? 8) Questions/Answers--Discussion Knowledge was measured by use of a “post test.” A score of 100% for correct responses will be required to pass. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined.	

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	During an interview, on 6/8/21 at 9:42 a.m., the Director of Nursing (DON) indicated Resident D had passed away last night, it was expected. He was a hospice resident. He was young. The doctor indicated he was advanced. He was a do not resuscitate (DNR). He did yell out a lot. His pain probably was not controlled. During an interview on 6/9/21 at 3:13 p.m., Licensed Practical Nurse (LPN) 21 indicated she had usually worked evening and night shifts. She usually worked the 100 hall and was familiar with Resident D. He had been admitted to the facility due to bladder cancer and was receiving hospice services. The hospice had done admission paperwork and for him on Wednesday (6/2/21). She had received report from day shift that nothing was unusual, he was OK. She gave him his 4:00 p.m. medications and he had asked for lorazepam [anxiety medication] and when smoke time was. She said she would check on him after she finished medication pass. The CNA came and told her he had a fall, when she went down to check on him, and he was already back in bed. She didn't know if he put himself back in bed, but he was capable of doing so. He had on some jogging pants dark in color, no shirt. She went to get him a gown, initiated vital signs, and neuros, they were all WNL (within normal limits), at 4:00 he had that pain pill, maybe that's why he wasn't in pain. The bed was in lower position, but not lowest. The bed was straight. He had nothing on his feet. He just didn't say anything about the fall just worried about smoking. No new injuries, he had some previous areas. She guessed he had a lot of edema, where he had been weeping and then some areas opened on bilateral lower extremities. The fall was unwitnessed, so we assumed he hit head that's why neuro checks were initiated. On the next 15 minutes check, he was still asking		Staff will not work until they receive the in-servicing and pass the post-test in this AOC.	

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	when it was time to go smoke, but at that time it was dinner time, so she moved the tray to him, dinner was already in the room. When she came back, still checking on him for fall follow up, he had eaten a little bit of the hot dog, all of the fruit and all of his juice. Did not go out to go smoke. Then she came back to check, he was still eating slow, then he stopped asking about smoking and he was just eating really slow, which was his usual, she told him she would take him out to smoke later. He had 2 falls. One before dinner and one after dinner. She went back to continue neuro checks, this time he was on the floor- right in front of his bed, laying on his right side facing the door, his eyes were closed. He was non-responsive to verbal stimuli, he just looked lifeless, his color hadn't changed it was still kind of pink, his eyes were closed. She flipped him onto his back and shook him, but he still did not respond, did sternal rub, no response. "I thought he was a no code. I had to leave him and go to the computer and see what his code status was, but it didn't say anything. So, I looked in the hospice binder, it didn't say anything. Then I grabbed my cell phone and went back to the room start calling everyone, called [DON], told her I didn't know code status, she didn't know it either. Then called hospice they told me he was a DNR." LPN 21 indicated she did not remember the timeline exactly, just a fall before dinner, and a fall after dinner. The dinner tray had already been picked up, before the second fall. Dinner was about 5:30 p.m. His vital signs, and the neuro checks she completed were on the front of his hard chart, but they weren't there when she looked again. It was possible the funeral home took his paperwork and took the vital sign sheet with them. Resident did not usually yell out on her shift. She thought he did it when he needed pain medication. Hospice had given a booklet to her on Wednesday before they left, after they had			

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	completed the admission. It was a bound booklet and she put it on his chart binder. It did not contain any orders or code status. No explanation was provided for the inconsistencies in the charting such as only documenting one fall, the documentation having vitals from a different date, or the resident being documented as found in the bed unresponsive instead of the floor. On 6/9/21 at 3:40 p.m., the DON provided a paper document, dated 6/7/21 and timed from 5:40 p.m. to 6:17 p.m., for Resident D with vital signs, recorded 7 times as within normal ranges. On 6/9/21 at 8:40 a.m., the Administrator (ADM) provided a current, undated policy, titled "Incidents/Accidents/Falls." This policy indicated "It is the policy of this facility to ensure that any incident/accident to include falls is reported immediately to the nurse or appropriate person designated to be in charge. After the resident has immediate attention and their safety is established, a written report will be entered into Risk Management...." The immediate jeopardy that began on 6/7/21 was removed on 6/11/21 when the facility audited all residents' records for falls to ensure assessments, notification as appropriate, and updated the residents' care plans and ensured proper footwear (non-skid socks) was provided. The staff was in-serviced on falls, physician notification, and sending residents to the hospital. The facility implemented a process to monitor for falls, physician notification, and transfers to the hospital. The noncompliance remained at the lower scope and severity level of isolated no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued			

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	monitoring. This Federal tag relates to Complaints IN00353332 and IN00353253. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure a dementia resident's behaviors resulting in safety issues were assessed and documented to ensure interventions and care were provided to ensure safety and dignity for 1 of 3 residents reviewed (Resident F). Findings include: On 6/8/21 at 9:20 a.m., Resident F was observed as he walked into his room. His mattress was on the floor with no pillow, sheet, or blanket. On 6/7/21 at 9:24 a.m., Resident F's room was observed. His mattress was on the floor without a pillow, sheet, or blanket. Resident F's record was reviewed on 6/7/21. Resident F's diagnoses included, but were not limited to, dementia with behavioral disturbance (brain disease marked by memory problems, impaired reasoning, aggression, and wandering), cognitive communication deficit (progressive	F 0744	**Allegation – F744 – Treatment/Service for Dementia** **What corrective action(s) will be accomplished for those residents found to have be affected by the deficient practice.** Resident F no longer resides at the facility. **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:** The Social Services Director and/or designee will audit current resident records to ensure the clinical record accurately reflects their behaviors and is reflected on their care. Any deficiencies noted will be corrected.	07/07/2021

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	brain disorder with difficulty thinking and expressing language, and delusional disorders (belief in altered reality). A care plan, dated 3/4/21, with no revision date, indicated Resident F was at risk for behavioral disturbances related to dementia with behavioral disturbances. An intervention indicated to observe for behaviors and to notify the MD (medical doctor), family, and interdisciplinary team (variety of staff members to determine the appropriate approaches for the resident's quality of care/life) of changes in his behavior. On 6/11/21 at 10:41 a.m., Resident F was observed laying on his mattress with no pillow, sheet, or blanket. He was on his side, holding his head up, with his arms wrapped around his body, his knees were bent. His air conditioner was running, and the air in the room was very cool. During an interview, on 6/11/21 at 10:43 a.m., Certified Nurse Aide (CNA) 13 indicated once Resident F was up, following him was like "the Boston Marathon." He was all over the place. During an interview, on 6/11/21 at 10:44 a.m., CNA 17 indicated the Administrator told her to put a sheet on the mattress and cover Resident F with a blanket. During an interview, on 6/11/21 at 10:46 a.m., CNA 13 appeared slightly agitated, when he indicated, "You have to use good judgment, this is memory care. He will wrap up his arms and legs and tie knots. He can only have them when he is sleeping." During an interview, on 6/11/21 at 10:48 a.m., Licensed Practical Nurse (LPN) 35 indicated		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The DON/Designee will in-service Staff on behavior management and tracking tool. Any staff that fails to comply with this in-service will be further educated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The behavior Tracking Tool will be audited 3x a week x 4 weeks, then weekly x 4 weeks, then monthly x 4 weeks. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter until substantial compliance is achieved. . Any concerns noted during the audits will be addressed immediately and any patterns identified in QA will be presented to the QAPI committee. QAPI committee will then write an action plan.	

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	Resident F always wandered. He entered Room 215 and drank water from the other resident's cups residing in that room. She believed Resident F was safe with a pillow, sheet, and blanket. During an interview, on 6/11/21 at 10:53 a.m., the DON indicated Resident F was care planned for not having a pillow, sheet, or blanket because he would have tied the sheet around himself. During an interview, on 6/11/21 at 5:36 p.m., the Regional MDS Consultant indicated there was no behavioral care plan regarding Resident F's additional behaviors of when he removed the sheet and blanket and tied himself up and tied knots in the fabric. She was unaware of this behavior. She was creating a care plan for this behavior now. During an interview, on 6/11/21 at 5:38 p.m., the DON indicated Resident F tied his sheet and blanket around himself and it was a safety hazard for him. She did not know if the facility had any documentation of Resident F's behaviors. During an interview, on 6/11/21 at 5:42 p.m., the Regional Nurse Consultant indicated she was unaware of Resident F's had this behavior. The facility will get him long sleeved shirts and she would find out why there were no progress notes or care plans regarding this behavior. A new care plan, dated 6/11/21, indicated Resident F untucked his sheets and tied knots around himself putting himself at risk for injury. No linens or blankets on his bed. A current policy, titled, "Resident Rights," with no date, was provided by the Administrator on 6/10/21 at 2:21 p.m. A review of the policy			

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	indicated, " ...The facility must care for you, in a manner and environment that enhances or promotes your quality of life...the facility will treat you with dignity...the facility must provide a safe, clean, comfortable, home-like environment...the facility will provide you with comfortable and safe temperature levels...." 3.1-3(t)			
F 0760 SS=E Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview and record review, the facility failed to follow standards of practice to ensure residents received physician prescribed medications during a random review of Medication Administration Records (MAR) for 9 of 12 residents reviewed for medication administration (D, J, K, L, M, P, Q, R and V). Findings include: On 6/7/21 at 9:15 a.m., during a random medication pass observation, Licensed Practical Nurse (LPN) 3 was observed as he passed medications to residents of the 100 Hall. LPN 3 opened the top drawer of the medication cart and removed cups of preset medications for each of the 11 residents, going room to room without having the medication administration open, in front of him. He did not document any medications at the time of the medication pass. On 6/8/21 at 10:00 a.m., the June Medication Administration Records (MAR) were reviewed, for residents of the 100 Hall. The documentation	F 0760	**Allegation F760 – Residents are free of significant med errors** **What corrective action(s) will be accomplished for those residents found to have be affected by the deficient practice** Licensed Nurse #3 no longer works at facility Resident on 100 hall way were assessed for negative effects. **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:** The DON/Designee audited all medication carts for medication availability. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	07/07/2021

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	indicated the following medications, and blood sugar checks were not given, there were no initials or codes in the administration box for the time of the ordered administration: a. Resident D, admitted on 6/1/21, the following medication was not given: On 6/4/21 at 9:00 a.m. lovenox 40 milligrams (mg) inject subcutaneously (under skin) for blood thinner. b. Resident J, admitted 5/12/21, the following medications were not given: On 6/6/21 at 9:00 p.m. hydroxyzine 50 mg for insomnia and artificial tears 1 drop in both eyes for dryness. c. Resident K, admitted 5/6/21, the following medications were not given: On 6/3/21 at 6:00 a.m., bezonate cap 100 mg for cough, omeprazole 40 mg for gastric reflux (stomach acid), voltarin gel topical analgesic (pain), albuterol nebulizer 1 vial for treatment for COPD (chronic obstructive pulmonary disease), tums chewable tabs (calcium) 2 tablets On 6/6/21 at 8:00 p.m. benzoate cap 100 mg for cough, at 9:00 p.m. latanoprost solution (eye drops) 1 drop in the left eye, melatonin 3 mg for sleep. d. Resident L, admitted on 5/20/21, medications were not administered (per gastric tube [g-tube]): On 6/3/21 at 6:00 a.m. aspirin 81 mg for heart health, folic acid 1 mg supplement, multivitamin, thiamin 100 mg supplement, apixaban 5 mg blood thinner, carvedilol 6.25 mg (blood pressure) and check blood pressure, lansoprazole 3mg/ml give 10 ml, levetiracetam 7.5 ml for seizures, blood glucose check.		**practice does not recur.** The DON/Designee will in-service Staff Medication Administration Policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Medication Administration Report will be audited 3x a week x 4 weeks, then weekly x 4 weeks, then monthly x 4 weeks. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter until substantial compliance is achieved. . Any concerns noted during the audits will be addressed immediately and any patterns identified in QA will be presented to the QAPI committee. QAPI committee will then write an action plan.	

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	On 6/6/21 at 8:00 p.m. pravastatin 40 mg for cholesterol, at 9:00 p.m. Insulin glargine 30 unit subcutaneously (injection), melatonin 3 mg for sleep, mirtazapine 15 mg (antidepressant) for appetite stimulation. e. Resident M, admitted on 6/1/21, the following medications were not given: On 6/6/21 at 9:00 p.m., atorvastatin calcium 40 mg for cholesterol, melatonin 10 mg for sleep, mirtazapine 15 mg for depression. f. Resident P, admitted 5/8/21, the following medications were not taken: On 6/3/21 at 6:00 a.m. blood sugar On 6/6/21 at 6:00 a.m. blood sugar, at 9:00 p.m. pramipexole 1.25 mg for Parkinson's Disease On 6/7/21 at 9:00 p.m. blood sugar g. Resident Q, admitted on 6/2/21, the following medications were not given: On 6/4/21 at 6:00 a.m. to 4:00 p.m. Premarin cream insert one tube in AM, one time a day On 6/6/21 at 9:00 p.m. Lipitor 40 mg for cholesterol, Combivent Respimat inhaler 1 puff, voltarin gel topical analgesic (for pain) h. Resident R, admitted on 6/1/21, the following medications were not given: On 6/4/21 at 9:00 change peripherally inserted central catheter (PICC) line administration set daily On 6/4/21 at 2:00 p.m. cefazolin 2 gram (gm) IV (intravenous) for infection On 6/5/21 at 6:00 a.m. cefazolin 2 gm IV (intravenous) for infection On 6/6/21 at 8:00 p.m. suboxone 8-2 mg for analgesia (for pain) On 6/6/21 at 10:00 p.m. cefazolin 2 gm IV			

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	(intravenous) for infection On 6/7/21 at 6:00 a.m. cefazolin 2 gm IV (intravenous) for infection i. Resident V, admitted on 6/3/21, the following medications were not given: On 6/6/21 at 5:00 p.m., Macrobid 100mg (antibiotic), at 9:00 p.m., melatonin 3 mg for sleep, gabapentin 300 mg for pain, and diclofenac sodium gel topical for pain. On 6/9/21 at 10:55 a.m., during an interview, the Director of Nursing (DON) indicated medication orders were on the EMAR (electronic medication administration record). The EMAR should have been used to prepare the medication pass, then documented as given. If the medication was not given, a reason for why it was not given must have been entered on the EMAR, it was a number code, with a key on the page they followed for the documentation. Blank spaces in the MAR meant either not given or gave and didn't sign off. "In the real world if it's not signed off it wasn't given." When medication was administered, they should have used the 5 rights of medication administration. To identify the resident, look at the picture, if they can't answer the questions, give the medication, then document it was given. They should not pre-set medications. It is the facility's expectation that that residents receive all prescribed/ordered medications. On 6/9/21 at 8:40 a.m., the Interim Administrator provided an undated, current policy, titled "Medication Administration Guidelines." This policy indicated "...The Right Resident...The Right Medication...The Right Dose...The Right Time...The Right Route...The Right Documentation...The Right To Be Informed...Standards of Practice, you are held			

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	accountable for professional standards of care...." This Federal tag relates to Complaints IN00353045, IN00353253, and IN00353332. 3.1-48(c)(2)			
F 0880 SS=F 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 observation, interview, and record	F 0880	**Allegation – F 880 – Infection**	07/07/2021

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	review, the facility failed to follow CDC (Centers for Disease Control and Prevention) guidance during a pandemic to ensure staff followed appropriate infection control requirements including the using PPE (personal protective equipment) appropriately and doing hand hygiene with PPE application/removal for 6 of 12 residents observed for infection control (Residents F, M, H, N, V, and Q). The facility failed to ensure residents (Residents H, V and Q) in isolation were monitored for signs and symptoms of the virus for 3 of 3 residents reviewed for infection control. The facility failed to ensure a memory care resident (Resident F) on COVID-19 precautions was assessed daily, had signage and PPE on his door for the "yellow zone" (isolation), and did not exposed 13 of 25 unvaccinated memory care residents on the unit for 1 of 1 resident in isolation on the memory care unit. The facility failed to remove 4 of 12 residents from isolation when their 14 day period was ended (Residents J, K, L, and P) which resulted in them being exposed by staff on the isolation hall when staff failed to use proper PPE for the yellow zone. Findings include: 1. On 6/8/21 at 8:55 a.m., Certified Nursing Assistant (CNA) 18 was observed in the memory care dining room. She wore a surgical mask below her nose. At this time, the Director of Nursing (DON) entered the memory care dining room and approached CNA 18. The DON indicated CNA 18 needed to pull her mask up over her nose and indicated there was a new "Yellow Room" on memory care. The DON indicated to CNA 18, a yellow room meant the resident was on isolation, and there would be a sign on the door with instructions on how to enter and exit the room. The DON briefly explained how to put on and take		**Prevention & Control** It is the practice of this facility to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease. All residents residing in the facility have the potential to be affected; however, no resident was affected. Root cause analysis worksheet was completed and the LTC infection control assessment has been completed. All staff received education on hand washing and donning and doffing of PPE by the DON or ADON and did a return demonstration. Hand washing and donning and doffing of PPE will be audited 3x a week x 4 weeks, then weekly x 4 weeks, then monthly x 4 weeks. The audits will be completed by the Executive Director, DON, ADON or MDS Coordinator. Any concerns noted during the audits will be addressed immediately and any patterns identified in QA will be presented to the QAPI committee. QAPI committee will then write an action plan.	

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	off PPE (personal protective equipment) and CNA 18 indicated she understood. During an interview on 6/8/21 at 9:00 a.m., CNA 18 indicated it was her very first day of work, she has just been hired and had not even had orientation yet. The DON had come to her to explain there was an isolation resident in the memory care and she needed to follow instructions on the door. On 6/8/21 at 9:07 a.m., CNA 17 and 18 were observed as they entered Resident F's room. They entered the room and wore only surgical masks. There was a plastic isolation bin outside of his door, and a sign was posted on his door which indicated, "YELLOW ROOM." Additional signs were posted with instructions for how to on/off the appropriate PPE. The signs indicated staff who entered should wear an N-95 mask, a face shield, an isolation gown, and gloves. At 6/8/21 at 9:10 a.m., Licensed Practical Nurse (LPN) 11 indicated the CNAs should have put on PPE before they entered the room because the resident was on precautionary isolation for COVID-19 after his return from the hospital. LPN 11 did not know if either CNA, or if the resident was vaccinated against COVID-19. During a continuous observation on 6/8/21 from 11:32 a.m. until 12:09 p.m. the following was observed: At 11:32 a.m., Resident M left his isolation room, he wore only a surgical mask, and walked through the isolation hallway, past the dining room where three unidentified residents sat, continued past the activity room, and entered the library/chapel. He sat at a desk and picked up the common-use Resident Phone to complete a call.			

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	At 11:49 a.m., the Administrator (ADM) exited Resident M's room. Her soiled PPE isolation gown was crumpled up in her hands and rested on top of a corded telephone base. At this time the ADM indicated, she had been in Resident M's room to replace his telephone since the one in his room was not working. At 11:57 a.m., LPN 19 was observed already in Resident H's room. She wore an isolation gown that was not tied in place and hung off her shoulders to the middle of her chest and remained open down the length of her back and legs. She did not have gloves on. Her N-95 face mask was not properly sealed, as the bottom strap was not in place. She held up a Smartphone, which did not have any protective barrier. Resident H was not wearing a mask and stood less than 6 feet away from the phone as he spoke on a video call. At 12:07 p.m., LPN 19 exited Resident H's room. She placed the Smartphone on the top of the PPE bin outside of Resident H's room, removed her isolation gown in the doorway, walked three doors down to a trash cart in the hallway and disposed of the soiled gown. She used an Alcohol Based Hand Rub (ABHR) to sanitize her hands. At 12:08 p.m., LPN 19 placed on a new isolation gown, but did not tie in in place, so it hung off her shoulders and to the middle of her chest and remained open down the length of her back and legs. She did not put on gloves and did not seal her N-95 face mask. She did not sanitize the Smartphone which had been used in the previous isolation room less than 6 feet away from a resident who spoke without a mask in place. LPN 19 entered Resident N's room with the Smartphone and closed the door behind her.			

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	At 12:09 p.m., Resident M returned to his room. On 6/8/21 at 3:11 p.m., LPN 19 was observed as she gathered supplies from a treatment cart. She approached Resident N's room. She placed the supplies on top of the PPE bin, and put on an isolation gown. She did not tie the gown in place and hung off her shoulders to the middle of her chest and remained open down the length of her back and legs. She did not put on gloves. On 6/8/21 at 3:19 p.m., LPN 19 exited Resident N's (yellow/isolation) room, removed her isolation gown in the hallway, carried the crumpled gown in her bare hands across the hall and placed it in a covered trash in the hall. At this time, she entered Resident K's (green/non-isolation) room, opened Resident K's bathroom door with her bare hand, and washed her hands at the sink for less than 20 seconds. During an interview, on 6/10/21 at 11:47 a.m., the Housekeeping Supervisor (HS) indicated, he had not been notified that an isolation resident (Resident M), had used the resident phone in the common area. If he had been notified, he would have had the phone and table the resident sat at disinfected. On 6/8/21 at 1:00 p.m., Resident M's medical record was briefly reviewed. Resident M admitted to the facility on 6/1/21 with a primary diagnosis of COPD (Chronic Obstructive Pulmonary Disease- a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and a history of Tuberculosis (a potentially serious infectious bacterial disease that mainly affects the lungs).			

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A physician's order to place the resident in isolation was not obtained until 6/7/21.

A baseline care plan dated 6/2/21 at 2:02 p.m., was incomplete and lacked documentation the resident should have been placed in precautionary isolation as a new admission to be monitored for signs and symptoms of COVID-19.

The record lacked documentation that a COVID-19 Symptom Screen had been completed on 6/2/21 and 6/4/21.

On 6/7/21 at 4:22 p.m., the Social Service Director, (SSD) provided a list of residents who were not vaccinated against the COVID-19 virus. Resident M was not vaccinated.

2. On 6/8/21 at 2:00 p.m. three residents' records were reviewed for COVID-19 infection prevention and control (Residents H, V and Q).

a. Resident H was admitted to the facility on 6/3/21 with acute respiratory failure.

A physician's order to place the resident in isolation was not obtained until 6/7/21.

A baseline care plan, dated 6/5/21 at 3:50 p.m., lacked documentation the resident should have been placed in precautionary isolation as a new admission to be monitored for signs and symptoms of COVID-19.

The record lacked documentation that a COVID-19 Symptom Screen had been completed on 6/3/21, 6/4/21 and 6/7/21.

On 6/7/21 at 4:22 p.m., the SSD provided a list of

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	residents who were not vaccinated against the COVID-19 virus. Resident H was not vaccinated. b. Resident V was admitted to the facility on 6/3/21 with a spinal cord infection. A physician's order to place the resident in isolation was not obtained until 6/7/21. A baseline care plan dated 6/5/21 at 2:35 p.m., indicated Resident V was a new admission and should be placed in isolation for 14 days. The record lacked documentation that a COVID-19 Symptom Screen had been completed on 6/3/21, 6/4/21, 6/7/21, 6/8/21 and 6/9/21. On 6/7/21 at 4:22 p.m., the SSD provided a list of residents who were not vaccinated against the COVID-19 virus. Resident V was not vaccinated. c. Resident Q was admitted on 6/2/21 with COPD. A physician's order to place the resident in isolation was not obtained until 6/7/21. A baseline care plan dated 6/2/21 at 4:17 p.m., was incomplete and lacked documentation the resident should have been placed in precautionary isolation as a new admission to be monitored for signs and symptoms of COVID-19. The record lacked documentation that a COVID-19 Symptom Screen had been completed on 6/2/21, 6/4/21, 6/7/21, 6/8/21 and 6/9/21. On 6/7/21 at 4:22 p.m., the SSD provided a list of residents who were not vaccinated against the COVID-19 virus. Resident Q was not vaccinated.3. On 6/7/21 at 9:24 a.m., Resident F did not have a			

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	yellow zone sign (transmission-based precaution) on his door and did not have a personal protective equipment (PPE) cabinet outside his door. On 6/7/21, during a continuous observation from 12:19 p.m. to 12:32 p.m., Resident F was in the memory care (MC) dining room without a mask. He had significant bruising on his right eye, bruises on both sides of his face, and a large scab that ran down the length of his left ear. Twelve unidentified residents were seated in the dining room, waiting for their lunches. Resident F was constantly wandering in and out of the tables. During an interview, on 6/7/21 at 12:21 p.m., Licensed Practical Nurse (LPN) 11 indicated Resident F was constantly walking and he wouldn't sit down for lunch until staff was ready to assist him with eating. On 6/7/21 at 4:24 p.m., the Social Services Director (SSD) provided COVID-19 vaccination documentation. Resident F had not received any COVID-19 vaccinations. In the memory care area, 13 of 25 residents, had not received any COVID-19 vaccinations. On 6/8/21 at 9:23 a.m., Resident F was observed at he wandered around the dining / activity room without a mask, Resident FF and Resident DD were in the room, neither wore masks. On 6/8/21 at 9:29 a.m., the Director of Nursing (DON) indicated she forgot to put the yellow precaution sign or PPE outside of Resident F's room and was concerned with his constant wandering and the exposure to the other memory care residents.			

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	On 6/8/21 on 11:34 a.m., Resident F's record was reviewed. The findings were as follows: Resident F's diagnoses included, but were not limited to, dementia with behavioral disturbance (brain disease marked by memory problems, impaired reasoning, aggression, and wandering), cognitive communication deficit (progressive brain disorder with difficulty thinking and expressing language, and delusional disorders (belief in altered reality). On 6/3/21 at 5:09 p.m., Resident F returned from the hospital. No screening for COVID-19 signs or symptoms were documented on 6/4/21, 6/5/21, or 6/6/21. On 6/7/21 at 1:23 p.m., a room change was made for Resident F. He was given a single occupancy room. A Potential for Exposure and Contracting COVID-19 care plan, dated 3/4/21, indicated, staff should have encouraged and observed Resident F for Social Distancing of 6 feet. A care plan, dated 3/9/21, indicated Resident F preferred not to wear a mask, but staff should have encouraged and reminded Resident F to wear a mask if he came out of his room for any reason. A care plan, dated 3/4/21, indicated Resident F was at risk for behavioral disturbances related to dementia with behavioral disturbances. Resident F should have had one on one care as needed. On 6/11/21, during a continuous observation from 12:36 to 12:40 p.m., Resident F was in the dining			

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	room without a mask There were nine unidentified residents in the dining room. He wandered in and out of the tables until he left the dining room on his own. During an interview, on 6/11/21 at 2:10 p.m., the DON indicated the staff had attempted to keep Resident F in his room and kept redirecting him. She had added an extra aide, but it was hard to do one on one with him. Her expectation was for the staff to always redirect him, even in the dining room. 4. On 6/7/21 at 9:15 a.m., during a medication pass observation, Licensed Practical Nurse (LPN) 3 was observed on the 100 Hall, as he began the morning medication pass. He wore a surgical mask, and no other PPE. A sign on a standing pole, with an attached hand sanitizer dispenser, indicated "Yellow Zone." There were 11 occupied resident rooms. Each room had a sign on the door which indicated "Transmission Based Precautions, Contact Droplet. PPE [personal protective equipment] Required ..." On 6/7/21 at 9:20 a.m., Resident K came out of their isolation room, wearing a surgical mask below their chin, and walked down the hallway toward the Nurses' Station. On 6/7/21 at 9:25 a.m., during an interview, LPN 3 indicated "These people here don't have nothing, they are just on this hall for 14-day observation. You don't need any special masks. We wear surgical mask everywhere in the building." Plastic carts with drawers, were observed outside each room, on the 100 Hall, Yellow Zone. The carts contained a box of gloves and a box labeled N-95 masks. Three carts contained 1 blue			

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	disposable cover gown. A double linen bag holder/cart was in the hall with a lid which covered the 2 bags. An open 3-tiered plastic cart was outside room 110. It had soiled breakfast trays stacked on it. On 6/7/21 at 9:30 a.m., during an interview the Director of Nursing (DON) indicated the 100 Hall was all Yellow Zone. It required N95 masks and all required PPE for Transmission Based Precautions (TBP) needed to be worn in resident rooms. On 6/7/21 at 9:36 a.m., during an interview and observation, Floor Tech (FT) 4 was observed on the 100 Hall wearing a black cloth face mask. He indicated he was just a Floor Tech, he didn't know he needed a special mask. On 6/7/21 at 9:40 a.m., LPN 3 was observed standing at the medication cart, wearing a surgical mask below his chin, wiping sweat from his face onto a paper towel. He poured a cup of water, took the water and medications to Resident M, without performing hand hygiene. Assisted resident to reposition in bed. Came out of room, no hand hygiene and pulled his mask below his chin, then opened the medication cart, and moved the preset cups of medications around in the drawer. On 6/7/21 at 9:45 a.m., Resident J came out of their room wearing surgical mask and walked down the hall, toward the Nurse's Station. On 6/7/21 at 9:51 a.m., LPN 3 continued to pass medications on the 100 Hall, wearing a surgical mask and no other PPE. On 6/7/21 at 12:00 p.m., LPN 3 was observed at the Nurses' Station with a surgical mask under his			

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	chin, hanging an IV [intravenous] on an IV pole, and removing the plastic film off a new face shield. On 6/7/21 at 12:05 p.m., LPN 3 was observed as he worked on a computer, at the Nurses' Station. He wore a surgical mask pulled below his chin, Qualified Medication Aid (QMA) 5 was standing at his shoulder, leaning forward showing him something on computer. On 6/7/21 at 12:06 p.m., an unidentified dietary aid pushed a 3-tier cart onto the 100 Hall with lunch trays and called out "You all's lunch trays are here." Certified Nurse Aid (CNA) 13 was observed as he came to the 100 Hall, from the Nurses' Station and delivered lunch trays to the residents in isolation rooms. He wore a surgical mask and no other PPE. On 6/7/21 at 12:12 p.m., CNA 13 was approached by the Activity Director and directed to put on additional PPE, a disposable gown, and sanitize his hands between rooms. He put on a blue disposable gown, open in the front, untied, with a face shield over his surgical mask and served meals to 2 rooms. CNA 13 handed a meal tray to LPN 3, for Resident R. LPN 3 entered the room, wearing no gown, he held an N95 mask over his mouth with his left hand, carried the tray with his right hand and entered the room. LPN 3 came out of the room still holding the mask in the palm of his hand, covering his mouth. He then stood in the hall, with the mask held over his mouth with his hand and conversed with several other staff members. On 6/7/21 at 12:17 p.m., the Activity Director approached again and offered additional direction to CNA 13. She informed the CNA to turn the gown around and change gowns at each room.			

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	CNA 13 disposed of the blue gown in the hall linen cart and put on a new one before entering each of the last 4 rooms and delivered the meal trays. He indicated he usually didn't work this hall. He had never been educated on proper PPE for isolation. On 6/7/21 at 12:20 p.m., LPN 3 was approached by the MDS (Minimum Data Set) Coordinator and instructed to put on a gown. He indicated there were no gowns available in the carts and there were no large gloves. On 6/7/21 at 12:24 p.m., CNA 13 was observed at the bedside of Resident V, cutting up his food and assisting him with his meal. He was still wearing a surgical mask with a face shield. On 6/7/21 at 12:25 p.m., Housekeeper 16 brought 2 boxes of disposable cover gowns to the 100 Hall and placed packets of gowns into the isolation carts. On 6/7/21 at 2:44 p.m., the DON provided a facility map, color coded for green (non-isolation rooms) and yellow (isolation rooms). The map indicated 4 rooms, on the 100 Hall were green. Residents J, K, L, and P were no longer coded as isolation rooms. On 6/7/21 at 3:24 p.m., during an interview the DON indicated she had changed 3 residents to green on the 100 Hall. They had completed their 14 days and should have come off isolation over the weekend, but they didn't have a different room to move them to, so they were still on the yellow hall. Their doors were still marked as yellow this morning. She had changed them to green in the afternoon, after lunch. On 6/9/21 at 8:40 a.m., the Interim Administrator			

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	(IADM) provided a current undated policy, titled "Medication Administration Guidelines." This policy indicated "...Standards of Practice, you are held accountable for professional standards of care...practice good hand hygiene...Use PPE as necessary...Follow the manufacturer's guidelines...." 5. During an interview on 6/7/21 at 9:19 a.m., the DON indicated, there were no COVID-19 positive residents in the facility, and all newly admitted residents were placed on the yellow zone (isolation and transmission-based precautions). The DON indicated, when going into a yellow zone (isolation) room, staff should wear a face shield, an N95 face mask, a disposable gown, and gloves. The DON indicated all staff, in every area of the facility were supposed to wear at least a surgical mask while they were in the facility and in resident rooms. On 6/7/21 at 9:29 a.m., the ADM and DON were notified were notified that LPN 3 had been observed on the yellow zone without proper PPE as they went into and out of multiple residents' rooms. LPN 3 had been observed to provide care to residents who were in the in isolation areas and wore only a surgical face mask, pulled down below his chin. The DON indicated she had spoken with LPN 3 earlier that morning by phone and he had assured her he was wearing proper PPE on the yellow zone. The DON indicated, "he lied to me. They're all [facility staff] testing me because I'm the new DON". During a continuous, uninterrupted observation of the yellow zone unit, that began on 6/7/21 at 9:50 a.m., and lasted until 10:58 a.m., LPN 3 was observed as he stood in the hallway, as he worked at a resident medication administration cart (a			

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	wheeled cart with drawers, used to store and organize, and accessed to administer, resident medications). He placed pills into a small plastic cup on top of the medication cart. CNA 13 stood next to and talked with LPN 3. LPN 3 and CNA 13 both wore a surgical face mask, that was pulled down to below their chins. During an interview at this time, LPN 3 indicated he was the nurse assigned to care for the residents on the yellow zone hall. LPN 3 then pulled his face mask over his mouth and nose and continued to prepare resident medications. He did not use hand sanitizer at that time. LPN 3 indicated all the residents in that hallway were on isolation because they had recently been admitted to the facility and needed to stay on isolation for what he thought was 10 to 14 days. He wore only a surgical face mask throughout his shift, which included when he went into isolation rooms. He indicated, sometimes he put on a gown, but he never wore an N95 face mask or a face shield when he went into isolation rooms because, "I didn't think we had to." LPN 3 then entered Resident V's room. A sign on door indicated the resident's room was yellow zone/isolation, and that PPE was required to enter which included a N95 face mask, a face shield, a single-use gown, and gloves. LPN 3 wore a surgical face mask as he entered the room. He did not perform hand hygiene or put on any other PPE before he entered the room. LPN 3 was observed through the resident's open door, as he spoke with Resident V. Resident V was observed and did not wear a face mask. LPN 3 cleared the resident's bedside table of trash and a meal tray using his bare hands, took tray with partially eaten food items, dishes, and silverware from the resident's isolation room, and placed the tray and dirty dishes onto a 3-tiered plastic cart with wheels in the middle of the hallway. LPN 3 then entered			

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	Resident D's room. A sign on the door indicated Resident D was in isolation precautions. LPN 3 did not use hand sanitizer or put on additional PPE before he entered the resident's room. Resident D was observed from the hallway as he stood, bent over so that his head almost touched his knees, on top of a large white piece of bed linen, the size of a bed sheet. The sheet was observed to be soiled with moderate amounts of food debris and appeared to be wet. The resident's room had food and other types of debris strewn about the floor, bed, and bedside table, all visible from the hallway. LPN 3 asked Resident D if he was still eating food from breakfast. The resident said no, and LPN 3 took the meal tray and dishes from the resident's room, and placed it on the plastic cart in the hallway. LPN 3 then went into Resident P's room. A sign on the door indicated Resident P was on isolation precautions. LPN 3 retrieved a meal tray and dirty dishes from the resident's room and brought the tray back to the cart in the middle of the hallway. LPN 3 did not put on additional PPE or use hand sanitizer before he entered Resident P's room. On 6/7/21 at 9:58 a.m., LPN 3 used hand sanitizer. This was the first time hand hygiene was performed during the continuous, uninterrupted observation that began at 9:50 a.m. During the observation, LPN 3 was observed going into and out of 3 resident isolation rooms without putting PPE or performing hand hygiene. The nurse came within less than 6 feet of each resident and touched items in the resident rooms with his bare hands, to include, but not limited to, blankets, beside tables, used napkins, dirty dishes, drink cups, and meal trays. During a random observation on 6/7/21 at 10:02 a.m., CNA 13 was observed as he exited a resident			

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	room with a surgical mask pulled down below his nose and mouth. CNA 13 held linens that had been rolled into a basketball sized ball. The linens were visibly soiled and wet. CNA 13 carried the linens through the hallway, past 2 other resident rooms, and disposed of the soiled linens into a lidded cart in the middle of the hallway. CNA 13 then returned to the resident room, wearing the same gloves. He did not use hand sanitizer before re-entering the resident's room. CNA 13 shut the door behind him. During an interview with the ADM and DON on 6/7/21 at 12:33 p.m., the DON indicated all facility staff were tested monthly for COVID-19, unless they had been fully vaccinated, based on instruction from the facility's corporate contact. Residents were tested if they came into contact with a COVID-19 positive staff member and/ or if the resident had signs and symptoms of COVID-19, such as fever, coughing, and shortness of breath. On 6/7/21 at 2:49 p.m., LPN 3 was observed as he exited Resident N's room. A sign on the door indicated Resident N was in isolation precautions. LPN 3 did not perform hand hygiene when he exited the isolation room. LPN then then walked down hall, out of the isolation unit, and into the nurses' station where he sat down at and began using a computer. LPN 3 did not use hand sanitizer before he entered the nurses' workspace and accessed a computer and workstation shared by other nursing staff. During a continuous, uninterrupted observation that began on 6/8/21 at 9:00 a.m., and lasted until 9:06 a.m., LPN 19 was observed as she walked onto the yellow hall. She had on a N95 face mask. LPN 19 was observed as she retrieved a face			

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	shield and a gown from a PPE cart outside of a resident room. LPN 19 put on the face shield and gown. She did not tie the gown around her neck and back. She walked down the hall, past 2 resident rooms, and went into Resident M's room. A sign on the door indicated Resident M was on isolation precautions. As LPN 19 entered the resident's room, her gown had fallen down so that the neck of the gown was level with the middle of her chest, which left her shoulders and upper chest exposed. LPN 19 did not use hand sanitizer or put on gloves before she went into the resident's room. At 9:05 a.m., LPN 19 exited Resident M's isolation, still wearing the gown and face shield. She brought out a meal tray with dirty dishes from the room, placed the tray and dishes on the meal cart on in hallway, and removed her gown. At that time, Resident P, (no longer in isolation as she had been the day before), approached LPN 19 and indicated she was cold. LPN 19, observed to still hold the soiled isolation gown wadded up in her left hand, touched Resident P's shoulder and indicated she would get the resident a blanket. LPN 19 then walked past the resident, went to a trash receptacle in the hallway, and disposed of the gown. LPN 19 walked over to a linen closet in the hallway, opened the door, and after handling several linen items in the closet, indicated to Resident P that there were no extra blankets in the closet. Resident P indicated she did have a blanket in her room. LPN walked across hall, past 2 resident rooms, and entered Resident P's room. A sign on door indicated the resident was now in green zone, and no longer on isolation precautions. LPN 19 retrieved a blanket from the resident's bed, brought it out to the hallway, and placed the blanket over the resident's lap. LPN 19 then touched the resident's shoulder again and			

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	asked if the resident felt warmer. At 9:06 a.m., LPN 19 used hand sanitizer for the first time since she entered and exited Resident M's isolation room. During an interview on 6/8/21 at 9:07 a.m. with Qualified Medication Aide (QMA) 5, she indicated, rooms with signs on the door that said yellow zone required staff to wear a N95 mask, face shield, disposable gown, and gloves before they entered that resident's room. QMA 5 indicated staff should wash their hands or use hand sanitizer before going into a resident's room, before putting on PPE, immediately after doffing PPE, and immediately after leaving a resident room. On 6/8/21 at 9:51 a.m., the ADM provided a policy titled, "COVID-19 PPE Zones Guidelines", dated updated 4/5/21. The ADM indicated this was the current policy in use by the facility at this time. All staff were aware of this policy and should be following it. ADM indicated LPN 3, "definitely should have been" wearing more than just a surgical mask when he went into isolation rooms. ADM indicated all the facility staff had been educated about PPE expectations in the isolation areas. She was not sure why some people followed the expectations and others did not. During a random observation on 6/12/21 at 9:17 a.m., a single-use isolation gown and a face shield were observed hung on the door, facing out into the hallway on the yellow zone unit. A sign on the door indicated the resident who resided there (Resident R) was on isolation precautions. At that time, CNA 18 was observed walking down the yellow zone hall and was interviewed. She indicated she was the CNA assigned to the yellow			

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	zone that day. She was not sure why a gown and face shield were hung on the resident's door. CNA 18 indicated PPE should be put on before entering an isolation room and should be removed and disposed of in the resident's room before exiting. On 6/7/21 at 3:26 p.m., the DON provided a packet of current facility policy. A policy titled, "Clinical Documents PPE and Universal Precautions Guideline." The policy was undated. The policy indicated, "... the scope of this guideline includes all healthcare professionals and individuals that will partake in the resident plan of care... ii droplet precautions involve droplets generated by the resident, the employee, or visitor primarily during coughing, sneezing, and talking or during the performance of certain procedures... This policy provided a step, by step guide for donning (putting on) PPE and doffing (taking off) PPE and indicated, "...[step] 1. Perform Hand Hygiene 2. Don Gown: fully covering torso from neck to knees, arms to end of wrists, 3. Tie/fasten in back of neck and waist... 8. Don gloves: extended to cover wrist of gown..." On 6/7/21 at 3:26 p.m., the DON provided a policy titled, "COVID-19 Vigilant - And Prepared" dated June 2020. The DON indicated this was the current policy used by the facility at that time. The policy indicated, "Clinical Response Referral/ Admit Strategy...All new admissions and readmissions will reside on the yellow prevention unit for a time frame of 14 days to monitor closely for COVID-19 symptoms... Yellow Preventative zone patients (admission/ readmission/ dialysis/ frequent exit of the facility) COVID-19 referral screening tool for all admissions or readmissions, Formal COVID-19 result reviewed, 14 day every 4-hour s/s [signs and symptoms] check, 14 day every 4 hour vital sign check...Infection			

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	Prevention and Control Assessment Tool...HCP [health care personnel] perform hand hygiene in the following situations: Before resident contact, even if PPE is worn; After contact with the resident...After removing PPE... EPA-registered hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2 [COVID-19] are available to allow for frequent cleaning of high-touch surfaces...EPA-registered disinfectants are prepared and used in accordance with label instructions ...." On 6/8/21 at 9:51 a.m., the ADM provided a policy titled, "COVID-19 PPE Zones Guidelines", dated updated 4/5/21. The ADM indicated this was the current policy in use by the facility at this time. The policy indicated, " ...I. Scope a. The scope of this guideline include all interdisciplinary members, visitors...II. Equipment required a. PPE for all zones...B. YELLOW ZONE (Potentially/ presumed positive, new admissions, readmissions...1.) Gown, N95 mask, face shield or goggles, gloves as usual 2.) Gowns CANNOT be worn throughout the unit... 7.) All patients in the Yellow Zone should have a sign on their doors indicating their zone and the proper PPE to be worn upon entering the room ...." CDC Guidance titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, Nursing Homes & Long-Term Care Facilities," updated 3/29/21, indicated, " ...Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room...Ensure EPA-registered, hospital-grade disinfectants are available to			

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	allow for frequent cleaning of high-touch surfaces and shared resident care equipment...Implement Source Control Measures. Source control refers to use of well-fitting cloth masks, facemasks, or respirators to cover a person ' s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing... Residents, if tolerated, should wear a well-fitting form of source control upon arrival and throughout their stay in the facility. Residents may remove their source control when in their rooms but should put it back on when around others (e.g., HCP or visitors enter the room) and whenever they leave their room, including when in common areas or when outside of the facility...HCP should wear well-fitting source control at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers...Create a Plan for Testing Residents and Healthcare Personnel for SARS-CoV-2...The plan should align with state and federal requirements for testing residents and HCP for SARS-CoV-2...Evaluate Residents at least Daily. Ask residents to report if they feel feverish or have symptoms consistent with COVID-19. Actively monitor all residents upon admission and at least daily for fever			

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	(temperature =100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry...New Admissions and Residents who Leave the Facility... In general, all other new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission ...."CDC Guidance titled, "Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings," indicated, "... 5a. Hand Hygiene... 2. Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient. b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices. c. Before moving from work on a soiled body site to a clean body site on the same patient. d. After touching a patient or the patient ' s immediate environment. e. After contact with blood, body fluids or contaminated surfaces. f. Immediately after glove removal...."3.1-18(b)(1)3.1-19(f)			
F 9999 Bldg. 00	3.1-18 INFECTION CONTROL PROGRAM (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows	F 9999	F9999 **What corrective action(s) will be accomplished for those residents found to have be affected by the deficient**	07/07/2021

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	no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) The baseline tuberculin skin testing should employ the two-step method. For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidenced by: Based on interview, and record review, the facility failed to ensure admission 2 step tuberculosis (TB) skin tests were administered and properly documented per policy for 10 of 11 residents reviewed for admission 2 step TB skin tests, (Residents D, H, J, K, L,V, P, Q, R and N). Findings include: On 6/8/21 at 9:00 a.m., 11 new admission residents' medical records were revived for immunizations and TB screenings (Residents D, H, J, K, L, M, N, V, P, Q, and R). The electronic record did not contain documentation for TB skin tests. Documentation was requested. On 6/9/21 at 1:12 p.m., the Assistant Director of		**practice.** Tuberculin Test will be administered to residents D, H, J, K, L, M, N, V, P, Q, and R if resident still resides at facility. **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:** The DON/Designee audited Immunization record for evidence of Tuberculin Test. Tuberculin Test will be administered if needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The DON/ADON will review new admission and current residents annually and administer Tuberculin Test if needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Tuberculin Test will be audited 3x a week x 4weeks, then weekly x 4 weeks, then monthly x 4 weeks. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter until	

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	Nursing (ADON) provided paper form documentation, titled PPD (purified protein derivative, TB test medication) Form, for Residents D, H, J, K, L,V, P, Q, R and M. She indicated she did not know if they were documented in the electronic record. The forms were kept in the Director of Nursing (DON) office. a. Resident D was admitted on 6/1/21, the paper document indicated he had a first step TB test administered to his left forearm on 6/1/21. The lot number was provided. No expiration date was provided. The administered dose was not provided. The form indicated the test was negative. It did not indicate the date the test was read, or the millimeters of induration (measurement of the wheel on the arm). b. Resident H was admitted on 6/3/21, the paper document indicated he had a first step TB test administered to his left forearm on 6/3/21. The lot number was provided. No expiration date was provided. The administered dose was not provided. The form indicated the test was negative. It did not indicate the date the test was read, or the millimeters of induration (measurement of the wheel on the arm). c. Resident J was admitted on 5/12/21, the paper document indicated he had a first step TB test administered to his left forearm on 5/12/21. The lot number was provided. No expiration date was provided. The administered dose was not provided. The form indicated the test was negative. It did not indicate the date the test was read, or the millimeters of induration (measurement of the wheel on the arm). d. Resident K was admitted on 5/6/21, the paper document indicated he had a first step TB test administered to his left forearm on 5/13/21, 7 days after admission. The lot number was provided. No expiration date was provided. The administered		substantial compliance is achieved.	

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	dose was not provided. The form indicated the test was negative. It did not indicate the date the test was read, or the millimeters of induration (measurement of the wheel on the arm). e. Resident L was admitted on 5/20/21, the paper document indicated he had a first step TB test administered to his right forearm on 5/20/21. The lot number was provided. No expiration date was provided. The administered dose was not provided. The form indicated the test was negative. It did not indicate the date the test was read, or the millimeters of induration (measurement of the wheel on the arm). f. Resident P was admitted on 5/8/21, the paper document indicated he had a first step TB test administered to his left forearm on 6/2/21. The lot number was provided. No expiration date was provided. The administered dose was not provided. The form indicated the test was negative. It did not indicate the date the test was read, or the millimeters of induration (measurement of the wheel on the arm). g. Resident Q was admitted on 6/2/21, the paper document indicated he had a first step TB test administered to his right forearm on 6/2/21. The lot number was provided. No expiration date was provided. The administered dose was not provided. The form indicated the test was negative. It did not indicate the date the test was read, or the millimeters of induration (measurement of the wheel on the arm). h. Resident R was admitted on 6/1/21, the paper document indicated he had a first step TB test administered to his left forearm on 6/1/21. The lot number was provided. No expiration date was provided. The administered dose was not provided. The form indicated the test was negative. It did not indicate the date the test was read, or the millimeters of induration (measurement of the wheel on the arm).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 00 B. WING	06/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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	i. Resident V was admitted on 6/3/21, the paper document indicated he had a first step TB test administered to his left forearm on 6/3/21. The lot number was provided. No expiration date was provided. The administered dose was not provided. The form indicated the test was negative. It did not indicate the date the test was read, or the millimeters of induration (measurement of the wheel on the arm). j. Resident N was admitted on 6/5/21, TB test documentation was requested, but not provided. On 6/9/21 at 3:41 p.m. DON indicated she was the only one certified to administer and read TB skin tests, at the facility, but she did not have her card because it was lost in a wallet and she had been unable to replace it. The documentation forms she had provided for resident tests should have a given date administered and a date read. There was only one date on the form, that was the date administered. They were read in 48 to 72 hours after the administration, but the completed forms were not dated. On 6/9/21 at 1:12 p.m., the ADON provided a current policy, dated 7/10/20, titled, "Tuberculosis Screening Guideline." This policy indicated "...Residents and employees will be tested on admission...the Mantoux [a type of skin test for TB] skin test must be read 48-72 hours after the injection by a qualified individual...the reading should be based on measurement of induration...and recorded in millimeters...." This state finding relates to Complaint IN00353332.			