STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155267	A. BUILDING 00 B. WING	11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

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F 0000 Bldg. 00	This visit was for the investigation of Complaint IN00420716. This visit included a Focused Infection Control Survey. Complaint IN00420716- No deficiencies related to the allegations were cited. Survey date: November 13, 2023. Facility number: 000168 Provider number: 155267 AIM number: 100267020 Census Bed Type: SNF/NF: 63 Total: 63 Census Payor Type: Medicare: 6 Medicaid: 46 Other: 11 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 14, 2023.	F 0000	/b>	
F 0880 SS=D 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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hope Bowman	RN, DNS	11/26/2023

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

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	§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 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			

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	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, record review, and interview, the facility failed to ensure staff wore the appropriate PPE (Personal Protective Equipment) for residents on droplet precautions with COVID-19 for 1 of 5 staff observed for infection control. (Dietary Aide 7) Findings include: 1. During an observation on 11/13/23 at 9:20 a.m., Dietary Aide 7 was observed to be in Resident E and F's room with a dry mop. The aide was sweeping the residents' floor. The sign on the door indicated the residents in the room were on droplet precautions. The staff member was not wearing an N95, eye protection, or a gown in the room. She was at the foot of the resident's bed,	F 0880	**Tag Cited: F-880** **§483.80 – Infection Control** **Issue Cited:** **Infection Prevention and Control** Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible	11/14/2023

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	sweeping the floor and conversing with Resident F. During an interview on 11/13/23 at 9:22 a.m., the IP (Infection Preventionist) indicated Residents E and F were both on droplet precautions for COVID-19. During an interview on 11/13/23 at 11:05 a.m., LPN (Licensed Practical Nurse) 5 indicated Residents E and F had COVID-19 currently and staff had to wear full PPE in the rooms. She believed they were in isolation until 11/14/23. a. The record for Resident E was reviewed on 11/13/23 at 11:20 a.m. The diagnosis included, but was not limited to, 2019-nCoV acute respiratory disease. The nurse's note, dated 11/5/23 at 9:31 a.m., indicated the resident was not feeling well. He had a poor intake and a temperature of 101.7. He was COVID positive upon testing. The physician was notified, and new orders were given for the resident to be in contact droplet isolation precautions. The physician's order, dated 11/5/23, indicated the resident was in contact droplet isolation related to being COVID-19 positive. b. The record for Resident F was reviewed on 11/13/23 at 11:25 a.m. The diagnosis included, but was not limited to, 2019-nCoV acute respiratory disease. The nurse's note, dated 11/6/23 at 10:34 a.m. indicated the resident tested positive for COVID-19. The resident was placed in isolation.		allegation of compliance. /b> **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident E, F and G are no longer on droplet isolation; resident did not have a negative outcome related to the alleged deficient practice Dietary Aide 7 was educated on the droplet plus isolation and the process for donning and doffing PPE **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents on droplet isolation have the potential to be affected by the alleged deficient practice. All staff were in-serviced on standard and transmission-based precautions policy, COVID-19 Resident policy including posting of isolation signs according to facility policy and CDC guidelines by the IP/designee by **November 14** **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?**	

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	The physician's note, dated 11/7/23 at 9:14 a.m., indicated the resident had tested positive for COVID-19 after having a fever of 102 and oxygen saturations that had been on the low side of normal. The physician's order, dated 11/6/23, indicated the resident was on contact droplet isolation precautions related to being COVID-19 positive. The isolation would end on 11/16/23. 2. During an observation on 11/13/23 at 10:35 a.m., Dietary Aide 7 was observed to be in Resident G's room dry mopping the floor. The sign on the resident's room door indicated the resident was in droplet precautions. The aide was wearing a gown, gloves, and surgical mask, but was not wearing an N95 mask or eye protection. During an interview on 11/13/23 at 10:36 a.m., Dietary Aide 7 indicated she normally worked culinary but was cleaning rooms that day. She didn't know if she was supposed to be wearing a different mask in the room she was in. She then looked at the sign on the door and indicated she was supposed to be wearing an N95 mask. She had been educated on the proper PPE to wear in droplet precaution rooms but had forgotten to don an N95. She then exited the room wearing her gown and gloves, walked to the isolation cart on the hall and obtained an N95 to don prior to re-entering the room. The record for Resident G was reviewed on 11/13/23 at 11:56 a.m. The diagnosis included, but was not limited to, personal history of COVID-19. The LTC Respiratory Surveillance Line List indicated Resident G had symptoms of a headache on 11/10/23 and tested positive for COVID-19.		A Root Cause Analysis will be conducted with a consultant Infection Preventionist, with input from the facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause. The facility LTC Infection Control Self-Assessment will be reviewed with the consultant IP to determine accuracy. All staff were in-serviced on standard and transmission-based precautions policy, COVID-19 Resident policy including posting of isolation signs according to facility policy and CDC guidelines by the IP/designee by **November 14** Daily observational rounds will be conducted on all shifts for 6 weeks until compliance is maintained by the IP/designee using the PPR observation tool for observational rounds tool to observe for infection control practices and use of PPE for droplet isolation room. IP/designee will complete at least 15 PPE observations per week using the PPE observation tool The consultant IP will provide ongoing training, oversight, resources, and competencies as needed based on the Observation Rounds Audit and QA tools identifying on-going areas of concern or not meeting threshold.	

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	The physician's order, dated 11/10/23, indicated the resident was on contact droplet isolation precautions related to being COVID-19 positive. During an interview on 11/13/23 at 10:48 a.m., the DON (Director of Nursing) indicated Dietary Aide 7 had been educated on the isolation policies and procedures by the IP, including garbing up and what to wear after she'd entered Resident E and F's room earlier. She did not have COVID currently and did not have any physician's orders to not wear an N95 mask. She did not typically do Housekeeping, she was pitching in. During an interview on 11/13/23 at 11:06 a.m., RN 4 indicated Resident G had COVID-19. During an interview on 11/13/23 at 11:14 a.m., the IP indicated she educated Dietary Aide 7 on 11/13/23 as soon as it was brought to her attention that she had entered Resident E and F's room without appropriate PPE. She educated her verbally on proper donning and doffing of PPE and isolation rooms. She told her to wear an N95, gown, and gloves. The written education was going to be done when she was less busy. She did a verbal education, and then she went back to the floor. Residents E, F, and G all currently had COVID-19 and staff should be wearing full PPE when entering their rooms. The Isolation Droplet/Contact Precautions Sign included, but was not limited to, "Staff and Providers Must ... wear all PPE listed below ... Gown ... N95 Respirator ... Eye Protection (Face Shield or goggles) ... gloves ..." The most current Standard and Transmission-Based Precautions (Isolation)		Ensure all staff are aware of residents with isolation precautions by notifying them during GEMBA and shift-to-shift report. **1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** QAPI tool for Transmission Based Precautions/Isolation will be completed 1x weekly for 4 weeks, Monthly x 3 months, and quarterly thereafter. This will be completed by IP/Designee. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the DPOC as needed with input and oversight from the Consultant Infection Preventionist for sustaining substantial compliance for no less than 6 months. After 6 months the QAPI committee will re-evaluate the continued need for the audit. 5 **Date of Compliance –** ="" b="">	

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	policy, included, but was not limited to, " ... Droplet Precautions ... In addition to standard precautions the following should be included ... Use of Personal Protective Equipment - Mask and face protection in addition to gown and gloves: Anyone who goes into the room should wear a mask/face protection within 3 feet of a resident ... Perform hand hygiene prior to entering the room ... Put on mask/face protection (according to procedure) upon entry to room ..." 3.1-18(b)(2)			