

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/23/2020
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE CARE STRATEGIES	STREET ADDRESS, CITY, STATE, ZIP COD 505 N GAVIN ST MUNCIE, IN 47303
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F 0000 Bldg. 00	<p>This visit was for a COVID-19 Focused Infection Control Survey.</p> <p>Survey dates: October 23, 2020.</p> <p>Facility number: 000311 Provider number: 15E064 AIM number: 100285520</p> <p>Census Bed Type: NF: 40 Total: 40</p> <p>Census Payor Type: Medicaid: 39 Other: 1 Total: 40</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 29, 2020.</p>	F 0000		
F 0880 SS=D Bldg. 00	<p>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.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>must include, at a minimum, the following elements:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p>			

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	<p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>1. Based on observation and interview, the facility failed to ensure residents were socially distanced in the common area and the dining room for 3 of 7 facility observations.</p> <p>2 Based on observation and interview, the facility failed to ensure residents were monitored for COVID-19 according to CDC guidance for 8 of 45 shifts reviewed.</p> <p>Findings include:</p> <p>1. a. During the initial tour of the facility, on 10/23/20 at 8:46 a.m. in the common area, a female resident was sitting in a facility chair, there was a female resident sitting to the right of her in a wheelchair facing her and they were having a conversation. A male resident was sitting in a Broda chair directly in front of the resident in the facility chair. The three residents were not wearing masks.</p>	F 0880	<p>F-880 A</p> <p>1. Administrator immediately reviewed placement of residents while in dining and activity setting. Tables were placed together allowing for a total of 5 residents in the dining room at any one time. A blue "x" was placed on the floor in the dining room to indicate where a chair must be placed while in the dining area to ensure and maintain appropriate social distancing. Residents strongly encouraged to wear facial covering while outside of room and educated as to the importance. Staff educated on the importance of making sure residents are socially distanced when out of their rooms, in hallway and common area. Chairs in common area were placed 6 feet apart.</p>	11/20/2020
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	<p>b. During an observation on 10/23/20 at 10:11 a.m. in the dining room, residents were attending an activity with music and drinks. The Activity Director was serving drinks in styrofoam cups and was singing with the residents, she was wearing a surgical mask and eye protection. Two female residents were sitting next to each other at a square table they were singing, they were not wearing masks. Two men were sitting across from each other at a square table, one resident was in a wheelchair the other resident was sitting in a Broda chair, they were not wearing masks. A female resident with a N95 covering her mouth with her nose exposed, had propelled herself away from a table she had been sitting across from another female resident in a wheelchair. The Activity Director walked up to the female resident with the N95 and her nose exposed, pushed her to another table next to a female resident in a Broda chair who did not have a mask on. At another table there was a female resident in a Broda chair sitting next to a female resident in a wheelchair, the resident in the wheelchair was singing, neither resident had a mask on. During the observation the Administrator indicated it was really hard to keep masks on the residents and that they were a behavior facility.</p> <p>During an interview with the Activity Director on 10/23/20 at 10:23 a.m. she indicated she had the residents use hand sanitizer when they go in and out of the dining room, she sanitized the tables after the residents were done. She wore a mask and eye protection at work and so far they had been pretty lucky. She completes one on ones with residents who do not come down to the dining room. They encouraged the residents to wear masks but with their population, it was hard to keep the residents in their masks.</p>		<p>2. Any residents have the potential to be affected. Ongoing, all residents will be encouraged to wear their facial coverings properly, while outside of their room and to maintain a minimum of 6 feet distance from peers.</p> <p>3. All staff in-serviced on new policy regarding continual reminding and encouraging of residents to properly wear facial coverings while outside of room. All staff in-serviced on continual reminding of residents to maintain at least 6 foot distancing from their peers, at all times. Staff educated on dining room seating by utilizing the blue "x" for chair placement and no more than five residents in the dining area at any one time. DON/Designee will make daily rounds at varied times of day, to ensure that all residents have facial coverings properly in place and all residents are maintaining at least six foot social distancing while out of their rooms.</p> <p>4. DON/Designee will report findings during monthly QAPI meeting and follow QAPI recommendations until facility has gone 6 months with no concerns.</p> <p>5. Date of completion 11-20-20</p> <p>F-880- B</p> <p>1. DON/Designee immediately completed audit of resident screens to ensure all temp logs were turned in and placed in temperature binder. She educated</p>		

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	<p>c. During an observation of the dining room during lunch on 10/23/20 at 11:43 a.m., there were three square tables with two residents at each table seated next to each other and two tables with two residents seated across from each other, the residents were eating lunch and not wearing masks.</p> <p>On 10/23/20 at 12:40 p.m. CNA 4 indicated for the most part they tried to keep the residents six foot apart from each other and tried to keep them across the table from each other and during lunch the residents sitting next to each other should have been sitting across from each other and it was hard to do that with the dining room was so small.</p> <p>On 10/23/20 at 1:58 p.m. the Administrator indicated the square tables in the dining room were 3 ½ feet wide.</p> <p>2. During an interview with the facility's Infection Preventionist on 10/23/20 at 10:45 a.m., she indicated they monitor resident temps and oxygen saturations twice daily for COVID-19 and was documented in the Temperature Binder.</p> <p>Review of the Temperature Binder for monitoring signs and symptoms of COVID-19 for the residents, on 10/23/20 at 11:07 a.m. indicated the following:</p> <p>On 10/1/20 at 8:00 p.m. was not completed for 16 of 42 residents.</p> <p>On 10/13/20 at 8:00 p.m. was not completed for 42 of 42 residents.</p> <p>The binder lacked documents for 10/17/20 and 10/18/20 for the a.m. shift and 10/19/20, 10/21/20</p>		<p>nursing staff on the importance of completing temp logs/COVID evaluations and placing in temp log book every shift.</p> <p>2. Any resident has the potential to be affected. COVID screening evaluation including temperatures and SpO2's was added to computer charting to ensure completion and accessibility of documentation, at all times.</p> <p>3. Staff educated on documentation changes from paper to computer for COVID-19 screens, including temperatures and SpO2's. DON/Designee will audit for completion of COVID-19 screening daily times 4 weeks, weekly times 8 weeks, and monthly times 3 months to ensure compliance.</p> <p>4. DON/Designee will report findings to administrator weekly and as needed and during monthly QAPI meetings until facility has gone through audit regimen, as outlined above with no concerns and follow QAPI recommendations.</p> <p>5. Date of completion 11-20-20</p>	

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F 0886 SS=D Bldg. 00	<p>and 10/22/20 for the p.m. shift.</p> <p>During an interview on 10/23/20 at 12:53 p.m., the facility's Infection Preventionist indicated sometimes the nurses would put the monitoring sheet on there own clipboards and had forgotten to put it back in the binder.</p> <p>During an interview with the Administrator on 10/23/20 at 3:00 p.m., she indicated she could not find a policy for monitoring or social distancing, but would follow the CDC recommended guidelines.</p> <p>3.1-18(b)(2)</p> <p>483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:</p> <p>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to:</p> <p>(i) Testing frequency;</p> <p>(ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;</p> <p>(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or</p>			

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	<p>suspected exposure to COVID-19;</p> <p>(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;</p> <p>(v) The response time for test results; and</p> <p>(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.</p> <p>§483.80 (h)(2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;</p> <p>§483.80 (h)(3) For each instance of testing:</p> <p>(i) Document that testing was completed and the results of each staff test; and</p> <p>(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.</p> <p>§483.80 (h)(4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.</p> <p>§483.80 (h)(5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.</p> <p>§483.80 (h)(6) When necessary, such as in emergencies due to testing supply</p>			

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	<p>shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.</p> <p>Based on record review and interview the facility failed to test employees according to their COVID-19 county positivity rate for 2 of 5 employees reviewed (Employee 5 and Employee 7).</p> <p>Findings include:</p> <p>Employee testing documentation for COVID-19 was reviewed on 10/23/20 at 2:30 p.m. There were holes in the documentation for employee testing.</p> <p>On 10/23/20 at 2:50 p.m. the Administrator indicated she may had not put the employee testing results onto the spread sheet but employees were tested twice weekly, on Monday's and Thursday's, due to the county positivity rate for COVID-19.</p> <p>During an interview with the Administrator on 10/23/20 at 3:00 p.m. she indicated she was unable to locate Employee 5's test results for the dates of 10/11/20 through 10/17/20 but thought for sure she had been tested.</p> <p>On 10/23/20 at 3:15 p.m. the Administrator indicated she was unable to locate Employee 7's test results. Employee 7 worked two days a week on night shift and she was unable to get to the facility in time to test her for the dates of 10/4/20 through 10/10/20. They would follow the CDC recommended guidelines for testing employees due to the county positivity rate.</p>	F 0886	<p>F- 886</p> <ol style="list-style-type: none"> 1. Administrator held post survey all-staff meeting, where infection preventionist reiterated importance of coming into facility for COVID-19 testing on scheduled testing dates every week. Posted sign in break room and on bathroom doors reminding staff of mandatory testing dates. 2. Any resident has the potential to be affected. Administrator and Infection Preventionist remind staff frequently of testing dates in addition to posted signs. 3. All staff in-serviced on the importance of COVID-19 testing on scheduled test dates with frequency according to the county positivity rate. Infection Preventionist posted testing time and dates in breakroom and employee bathrooms and will follow up if someone does not show for scheduled testing. Staff will no be permitted to work until they have been tested if they missed the testing date. 4. Infection Preventionist will maintain spreadsheet of testing and report any positive test results or any staff failure to appear for testing to Administrator, immediately, and report compliance during monthly QAPI 	11/20/2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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			meeting and follow QAPI recommendations, until facility has gone four months with no concerns. 5. Date of completion 11-20-20		