STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155275	A. BUILDING 00 B. WING	11/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF PRINCETON, THE	1020 W VINE ST PRINCETON, IN 47670

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. Survey dates: November 20, 2020 Facility number: 000175 Provider number: 155275 AIM number: 100274440 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 45 Medicaid: 10 Other: 2 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 25, 2020.	F 0000	We are hereby respectfully requesting a desk review. Preparations and\or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and\or executed in compliance with state and federal laws. The facility respectfully requests paper compliance for citation	
F 0880 SS=E 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.			

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

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

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	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 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

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	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 review, the facility failed to properly utilize PPE (personal protective equipment) to prevent the spread of COVID-19 for 13 of 13 residents residing on the 100 hall. Four facility staff were not properly wearing N95 masks, and a CNA failed to apply a protective isolation gown and gloves as required in a Yellow Zone droplet precaution room, prior to caring for resident. (Resident 38, 100 Hall, RN 1, CNA 1, CNA 2, CNA 3) Findings include: 1. On 11/20/20 at 12:36 p.m., during the entrance conference, the Administrator was observed to be wearing a face shield and a N95 mask utilizing 1 strap around her head, the remaining strap was dangling under her chin. She indicated she was aware she should be utilizing	F 0880	**F880** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** The Administrator, RN #1, CNA #2 & #3 have been re-educated on how to properly wear the N95 mask. CNA#1 has been re-educated on PPE requirements in a Yellow zone with transmission-based precautions. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All other residents have the potential to be affected by the	12/18/2020

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	both straps for appropriate fit of the N95 mask. The Administrator indicated 6 of the 7 residents who tested positive for COVID-19, with results received today, had resided on the hallway where her office was located, the 100 hall with Rooms 102-115. On 11/20/2020 at 1:15 p.m., the Administrator provided the resident listing which indicated 13 residents remained on the 100 hall and were considered Yellow Zone for droplet precaution. 2. On 11/20/2020 at 1:22 p.m., RN 1 was observed on the Yellow Zone 100 hall wearing a face shield and a N95 mask with only 1 strap utilized to secure mask around her head. The second strap was visualized under the chin area of the mask, preventing the mask to fit against the face properly. 3. On 11/20/2020 at 1:24 p.m., CNA 1 was observed to be in at bedside of Resident 38, removing the top sheet covering the resident. The sign on the door of Resident 38 indicated Yellow zone, droplet precautions. CNA 1 was observed wearing a face shield and N95 mask and lacked an isolation gown and gloves. 4. On 11/20/2020 at 1:26 p.m., CNA 2 was observed to have an isolation gown in her hand returning to Resident 38's room doorway from the front of the hallway. CNA 2 was observed to be wearing a face shield and a N95 mask with only 1 strap utilized around her head, the remaining strap was laying across the nose area of the mask, preventing the mask to fit against the face properly. On 11/20/2020 at 3:34 p.m., the ADON (Assistant Director of Nursing) indicated CNA 1		alleged deficient practices. Education has been provided. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice:** Staff will be re-educated by the IP nurse/DON/IP nurse consultant and or designee on the following: PPE guidelines to include donning and doffing of all PPE equipment following policy “Covid-19 PPE Zone guidelines” with a return demonstration by 12/18/20. **How the corrective actions will be monitored to ensure the deficient practices will not recur:** The DON and/or designee will utilize the audit tool entitled Personal Protective Equipment (PPE) Competency Validation for 5 staff members on different shifts and all departments daily for 6 weeks, then once a week for two weeks, then monthly for four months. Any concerns will be immediately corrected. Results on monitoring will be further reviewed in QAPI and if trends are identified then another action plan may be developed 12/18/2020	

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	had only worked in the building 2 days, and should have been wearing an isolation gown and gloves in the Yellow zone, droplet precaution room. 5. On 11/20/2020 at 5:00 p.m., CNA 3 walked to the kitchen door in the service hallway and rang for a kitchen staff person. She was observed to lower her mask to speak to the kitchen staff, raise it again to cover her mouth and nose, and then walk to the nurse's station. CNA 3 was observed wearing a face shield and a N95 mask with only 1 strap in use, preventing the mask to fit against the face properly. CNA 3 indicated she only had 1 strap on the N95 mask and would obtain a new one. On 11/20/2020 at 3:58 p.m., the ADON provided the current facility policy, COVID-119 [sic] PPE Zones Guidelines, undated. The Policy indicated, but was not limited to, "YELLOW ZONE-PREVENTION/READMISSION/NONSUSPECTED COVID-19 Unit. Mask (surgical mask), gown, gloves. If positive residents reside in the facility, refer to SUSPECTED COVID-19 Yellow Zone guideline ...the prevention unit will be used for monitoring of symptoms based on a preventative action and unknown COVID-19 exposure or transmission that do not present with symptoms consistent with COVID-19 ..." 3.1-18(b)(1)			