STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS FELLOWSHIP COMMUNITY	2030 CHESTER BLVD RICHMOND, IN 47374

(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
R 0000 Bldg. 00	This visit was for a Residential COVID-19 Quality Assurance Walk Through. This visit included a State COVID-19 Quality Assurance Walk Through. Survey date: November 15, 2021 Facility number: 001128 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 22, 2021	R 0000	Plan of correction completed for R 0407, R 0414 and S 9999 on 12/3/21.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview, and record review, the facility failed to don and doff PPE (personal protective equipment) appropriately and ensure used PPE was contained within trash	R 0407	Please accept this plan of correction as the facility's credible allegation of compliance for Infection Control Survey	12/03/2021

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

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	receptacles for 22 of 22 residents in the memory care unit of the facility. Findings include: An entrance conference was conducted with the DON (Director of Nursing) and DMC (Director of Marketing and Communications) on 11/15/21 at 1:00 p.m. They indicated all of the residents in the memory care unit of the facility were in TBP (transmission based precautions) due to exposure to Covid positive staff. Staff were to don the required PPE prior to entering the unit. The DON provided a list of 22 Residents in the memory care unit of the facility on 11/15/21 at 2:30 p.m. The list read at the top "All in TBP d/t [due to] outbreak testing/contact tracing." A tour of the facility was conducted with the DON on 11/15/21 at 1:15 p.m. During the tour, an observation of the breezeway, entryway/hallway area located just prior to entering the memory care unit, was made. There was a trash receptacle outside of the double entryway doors into the memory care unit. The receptacle had used gowns hanging out of the top and sides of the receptacle with the lid resting on top. There was a yellow stop sign on the double entryway doors into the unit. The stop sign indicated contact droplet precautions requiring an N95 mask, eye protection, a gown, and gloves. Porter 2 approached the entryway doors wearing a surgical mask and pushing a rolling bin of trash. Porter 2 informed the DON he was going into the memory care unit to collect trrash. Porter 2 retrieved PPE from a box of PPE located next to the trash receptacle. He applied a gown, then gloves, then an N95 mask directly over his surgical mask, then eye protection glasses and		completed on 11/15/21. Infection Prevention and Control: The facility has established an infection prevention and control program with associated policy and procedures to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Identification of residents with potential to be affected by noncompliance of Infection Control policy and procedures: All residents have the potential to be affected by the deficient practice. 410 IAC 16.2-3.1-18 Affected: 16-18-5-1 410 IAC 16.2-5-12 (b) (1-4) Corrective actions put into place due to deficient practices as listed above: • Infection Preventionist provided education on hand hygiene, donning and removing personal protective equipment, standard precautions and handling of soiled linen on the following dates to each department: o Nursing staff- 11/17/21 o Dietary, Life Enhancement, Environmental Services,	

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	entered the memory care unit. He did not perform hand hygeine prior to applying the PPE. Porter 2 was observed to exit the memory care unit still wearing his gown, gloves, and N95 mask. Porter 2 removed his N95 mask and proceeded to remove the trash from the overflowing trash receptacle located next to the box of PPE and placed it into his rolling trash bin. Porter 2 then removed his gown and then his gloves. CNA 3 approached the entryway doors to the memory care unit wearing a surgical mask. CNA 3 retrieved retrieved PPE from the box of PPE. She did not perform hand hygeine and proceeded to don a gown, then answer her phone from her pocket and place it back into her pocket, then performed hand hygeine, then applied an N95 mask over her surgical mask, then applied a face shield and gloves and entered the memory care unit. An interview was conducted with the DON during the above breezeway observation. She indicated the used gowns should not be sticking out of the trash receptacle, and Porter 2 removed his gown and then gloves, which was wrong. The Use Personal Protective Equipent (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 guidelines was provided by the DON on 11/15/21 at 2:30 p.m. It read, "Donning (putting on the gear): ...1. Identify and gather the proper PPE to don...2. Perform hand hygiene using hand sanitzer. 3. Put on isolation gown...4. Put on NIOSH-approved N95 filtering a facepiece respirato or hiigheer...5. Put on face shield or goggles....6. Put on gloves....7. HCP [Health care personnel] may now enter patient room. Doffing (taking off the gear): ...1. Remove gloves....2. Remove gown....3. HCP may now exit patient room. 4. Perform hand		Maintenance and Administrative staff-11/18/21 • Post test for Hand Hygiene and Standard Precautions distributed to all department directors to give to all staff on 11/18/21. • Education regarding infection control policy and procedures and standard precautions including hand hygiene, donning and removing personal protective equipment, standard precautions and handling of soiled linen will be provided to each department monthly by the Infection Preventionist, or designee. Staff educated will be documented monthly and returned to the Infection Preventionist. 410 IAC 16.2-3.1-18 Affected: 16-18-5-1 410 IAC 16.2-5-12 (b) (1-4) System Changes: -Infection Preventionist has completed infection control rounds in yellow transmission-based areas. Immediate action was taken for the following: o Trash bins were moved from outside resident room to inside resident room at exit to ensure staff are removing personal protective equipment as close to exit as possible and to ensure no transmission is possible to hallway. This was completed by end of day 11/15/17.	

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	hygiene. 5. Remove face shield or goggles...6. Remove and discard respirator...7. Perform hand hygiene after removing the respirator/facemask...."		o Standing alcohol-based hand sanitizing station was relocated in The Courtyards breezeway and placed directly under keypad prior to entering The Courtyards. This was completed on 11/15/21. o Trash bin in The Courtyards breezeway was removed and placed directly inside the doors of The Courtyards so staff are removing personal protective equipment immediately prior to exit of The Courtyards. This was completed on 11/17/21. System Changes continued: Hand sanitizer has been placed at all personal protective equipment stations- 11/17/21 o Purchasing notified on 11/17/21 of need to inquire regarding wall mounted hand sanitizing stations to be placed in the Healthcare Center and The Courtyards to increase employee compliance with hand hygiene. o Purchasing ordered wall mounted hand sanitizing stations for the Healthcare Center and The Courtyards on 11/19/21. o Director of Maintenance notified of arrival of wall mounting hand sanitizing stations on 11/23/21. • Success Evaluation: How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance measures will be put into action for the following: 410 IAC 16.2-3.1-18	

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			Affected: 16-18-5-1 410 IAC 16.2-5-12 (b) (1-4) • Wall mounted sanitizing stations arrived on 11/23/21. Director of Maintenance notified of arrival of hand sanitizing stations and will be installed in The Courtyards on 12/2/21 Post- test for Hand Hygiene and Standard Precautions distributed to Department Directors on 11/22/21. Tests will be completed by all staff and returned to Infection Preventionist, or designee. Infection Preventionist, or designee, will grade all tests by 12/4/21. • Expectation will be that all staff will pass test with 90%. Those that do not pass with minimum of 90% will receive re-education from Infection Preventionist, or designee. • Nursing Leadership and the Infection Preventionist, or designee, will provide increased focused efforts on infection control practices with specific focused infection control surveys to ensure compliance. • Infection control observations and surveillance will be increased to daily x 4 weeks (beginning on 11/17/21-12/15/21) and then weekly thereafter. This will be performed to determine if staff are following appropriate standard and transmission- based precautions	

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			during periods of heightened surveillance and during times when a resident is placed in yellow or red zone for COVID-19 transmission- based precautions. The infection control observations will be reviewed monthly during Quality Assurance meetings. • The Infection Preventionist, or designee, will randomly select employees from the following departments: Nursing, Environmental Services, Dietary, Maintenance, Life Enhancement and Administrative staff. • The Infection Preventionist, or designee, will observe for appropriate implementation of standard and transmission-based precaution, including hand hygiene, respiratory/cough etiquette and appropriate donning and removing of personal protective equipment. Observations will be recorded on the Infection Control Observation log and recorded as pass or fail. Failures will be recorded on a validation checklist to review findings with the employee and provide the employee with corrective action as needed. The Infection Preventionist provided education to all departments on 11/17/21 and 11/18/21 regarding proper containment of soiled personal protection equipment. All staff and departments will be responsible	

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			for ensuring soiled personal protection equipment is properly placed in trash receptacle and appropriately covered so nothing is exposed. Trash will be emptied immediately upon filling. • The Infection Preventionist, or designee, and members of Nursing Leadership will complete observation and surveillance during the infection control observations and surveillance schedule. This will be daily x 4 weeks (beginning 11/17/21-12/15/21) and then weekly thereafter. The infection control observations will be reviewed monthly during Quality Assurance meetings.	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to perform hand hygiene appropriately for 2 of 2 randomly observed staff members (Porter 2 and CNA-Certified Nursing Assistant 3). Findings include: An entrance conference was conducted with the	R 0414	Please accept this plan of correction as the facility's credible allegation of compliance for Infection Control Survey completed on 11/15/21. Infection Prevention and Control: The facility has established an infection prevention and control	12/03/2021

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	DON (Director of Nursing) and DMC (Director of Marketing and Communications) on 11/15/21 at 1:00 p.m. They indicated all of the residents in the memory care unit of the facility were in TBP (transmission based precautions) due to exposure to Covid positive staff. Staff were to don the required PPE (personal protective equipment prior to entering the unit. The DON provided a list of 22 Residents in the memory care unit of the facility on 11/15/21 at 2:30 p.m. The list read at the top "All in TBP d/t [due to] outbreak testing/contact tracing." A tour of the facility was conducted with the DON on 11/15/21 at 1:15 p.m. During the tour, an observation of the breezeway, entryway/hallway area located just prior to entering the memory care unit, was made. There was a yellow stop sign on the double entryway doors into the unit. The stop sign indicated contact droplet precautions requiring an N95 mask, eye protection, a gown, and gloves. Porter 2 approached the entryway doors wearing a surgical mask and pushing a rolling bin of trash. Porter 2 informed the DON he was going into the memory care unit to collect trash. Porter 2 retrieved PPE from a box of PPE located next to an overflowing trash receptacle. He applied a gown, then gloves, then an N95 mask directly over his surgical mask, then eye protection glasses and entered the memory care unit. He did not perform hand hygiene prior to applying the PPE. CNA 3 approached the entryway doors to the memory care unit wearing a surgical mask. CNA 3 retrieved PPE from the box of PPE. She did not perform hand hygiene and proceeded to don a gown, then answer her phone from her pocket and place it back into her pocket, then performed hand hygiene, then applied an N95		program with associated policy and procedures to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Identification of residents with potential to be affected by noncompliance of Infection Control policy and procedures: All residents have the potential to be affected by the deficient practice. 410 IAC 16.2-3.1-18 Affected: 16-18-5-1 410 IAC 16.2-5-12 (b) (1-4) Corrective actions put into place due to deficient practices as listed above: • Infection Preventionist provided education on hand hygiene, donning and removing personal protective equipment, standard precautions and handling of soiled linen on the following dates to each department: o Nursing staff- 11/17/21 o Dietary, Life Enhancement, Environmental Services, Maintenance and Administrative staff-11/18/21 • Post test for Hand Hygiene and Standard Precautions distributed to all department directors to give to all staff on 11/18/21.	

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	mask over her surgical mask, then applied a face shield and gloves and entered the memory care unit. An interview was conducted with Porter 2 upon exit of the memory care unit. He indicated he didn't remember if he'd used hand sanitizer prior to donning his PPE, but he had some available, and held up a bottle of hand sanitizer he retrieved from his rolling trash bin. An interview was conducted with the DON during the above breezeway observation. She indicated she did not think Porter 2 performed hand hygiene prior to donning his PPE. The hand sanitizer pump located in the middle of the hallway should be moved closer to the memory care entryway for use. The Hand Washing policy was provided by the DON on 11/15/21 at 2:30 p.m. It read, "Observe standard precautions or appropriate infection control measures. Follow the Centers for Disease Control (CDC) guidelines for hand washing." The Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 CDC guidelines was provided by the DON on 11/15/21 at 2:30 p.m. It read, "Donning (putting on the gear): ...1. Identify and gather the proper PPE to don...2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown...4. Put on NIOSH-approved N95 filtering a facepiece respirator or higher...5. Put on face shield or goggles....6. Put on gloves....7. HCP [Health care personnel] may now enter patient room. Doffing (taking off the gear): ...1. Remove gloves....2. Remove gown....3. HCP may now		• Education regarding infection control policy and procedures and standard precautions including hand hygiene, donning and removing personal protective equipment, standard precautions and handling of soiled linen will be provided to each department monthly by the Infection Preventionist, or designee. Staff educated will be documented monthly and returned to the Infection Preventionist. 410 IAC 16.2-3.1-18 Affected: 16-18-5-1 410 IAC 16.2-5-12 (b) (1-4) System Changes: -Infection Preventionist has completed infection control rounds in yellow transmission-based areas. Immediate action was taken for the following: o Standing alcohol-based hand sanitizing station was relocated in The Courtyards breezeway and placed directly under keypad prior to entering The Courtyards. This was completed on 11/15/21. Hand sanitizer has been placed at all personal protective equipment stations- 11/17/21 o Purchasing notified on 11/17/21 of need to inquire regarding wall mounted hand sanitizing stations to be placed in the Healthcare Center and The Courtyards to	

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	exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles...6. Remove and discard respirator...7. Perform hand hygiene after removing the respirator/facemask...."		increase employee compliance with hand hygiene. o Purchasing ordered wall mounted hand sanitizing stations for the Healthcare Center and The Courtyards on 11/19/21. o Director of Maintenance notified of arrival of wall mounting hand sanitizing stations on 11/23/21. Success Evaluation: How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance measures will be put into action for the following: 410 IAC 16.2-3.1-18 Affected: 16-18-5-1 410 IAC 16.2-5-12 (b) (1-4) • Wall mounted sanitizing stations arrived on 11/23/21. Director of Maintenance notified of arrival of hand sanitizing stations and will be installed in The Courtyards by end of week 12/4/21. NOTE: 2nd case of sanitizing stations have been ordered; and set to arrive 12/1/21. These will be mounted in the Healthcare Center upon arrival to facility and after The Courtyards sanitizing wall mounts have been mounted. Post- test for Hand Hygiene and Standard Precautions distributed to Department Directors on 11/22/21. Tests will be completed by all staff and returned to Infection Preventionist, or	

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			designee. Infection Preventionist, or designee, will grade all tests by 12/4/21. • Expectation will be that all staff will pass test with 90%. Those that do not pass with minimum of 90% will receive re-education from Infection Preventionist, or designee. • Nursing Leadership and the Infection Preventionist, or designee, will provide increased focused efforts on infection control practices with specific focused infection control surveys to ensure compliance. • Infection control observations and surveillance will be increased to daily x 4 weeks (beginning on 11/17/21-12/15/21) and then weekly thereafter. This will be performed to determine if staff are following appropriate standard and transmission- based precautions during periods of heightened surveillance and during times when a resident is placed in yellow or red zone for COVID-19 transmission- based precautions. The infection control observations will be reviewed monthly during Quality Assurance meetings. • The Infection Preventionist, or designee, will randomly select employees from the following departments: Nursing, Environmental Services, Dietary, Maintenance, Life Enhancement and Administrative staff. • The Infection Preventionist, or	

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			designee, will observe for appropriate implementation of standard and transmission-based precaution, including hand hygiene, respiratory/cough etiquette and appropriate donning and removing of personal protective equipment. Observations will be recorded on the Infection Control Observation log and recorded as pass or fail. Failures will be recorded on a validation checklist to review findings with the employee and provide the employee with corrective action as needed.	
S 0000 Bldg. 00	This visit was for a State COVID-19 Quality Assurance Walk Through. This visit included a Residential COVID-19 Quality Assurance Walk Through. Date: November 15, 2021 Facility number: 001128 Census Bed Type: Residential: 94 NCC: 32 Total: 126 Census Payor Type: Other: 126 Total: 126	S 0000	Plan of correction completed for R 0407, R 0414 and S 9999 on 12/3/21.	

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	These State Findings are cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 22, 2021			
S 9999 Bldg. 00	410 IAC 16.2-3.1-18 Infection control program Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1 Sec. 18. (a) The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection....(l) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to perform hand hygiene and don and doff PPE (personal protective equipment) appropriately; ensure soiled linen was contained during transport; ensure used PPE was contained within trash receptacles; and ensure trash receptacle placement for doffing PPE was inside of residents' rooms who were on TBP (transmission based precautions) for 9 of 15 residents in TBP (Residents B, C, D, E, F, G, H, J, and K) Findings include: An entrance conference was conducted with the DON (Director of Nursing) and DMC (Director of Marketing and Communications) on 11/15/21 at 1:00 p.m. They indicated 15 residents in the	S 9999	Please accept this plan of correction as the facility's credible allegation of compliance for Infection Control Survey completed on 11/15/21. Infection Prevention and Control: The facility has established an infection prevention and control program with associated policy and procedures to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Identification of residents with potential to be affected by noncompliance of Infection Control policy and procedures: All residents have the potential to be affected by the deficient practice. 410 IAC 16.2-3.1-18 Affected: 16-18-5-1 410 IAC 16.2-5-12 (b) (1-4)	12/03/2021

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		A. BUILDING 00 B. WING	11/15/2021

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	health care center of the facility were in TBP due to exposure to Covid positive staff. On 11/15/21 at 2:30 p.m., the DON provided a list of 15 residents in the health care center of the facility who were in TBP. The list included Residents B, C, D, E, F, G, H, J, and K. A tour of the facility was conducted with the DON on 11/15/21 at 1:15 p.m. During the tour, an observation of the health care center was made. There were yellow stop signs indicating contact droplet precautions on the room doors of Residents B, C, D, E, F, G, H, J, and K. There were trash receptacles for doffing PPE located outside their rooms. The trash receptacle between Resident G's and Resident H's room had used gowns exposed, sticking out of the top. CNA (Certified Nursing Assistant) 4 exited Residents C's and D's room wearing a gown. She removed her gown outside of the room and threw it into the trash receptacle located outside of the room. She did not perform hand hygiene after removal. CNA 4 was observed to don PPE to enter another resident's room who was in contact droplet precautions. She was already wearing a surgical mask and face shield. She donned a gown, then retrieved gloves out of a PPE bin, donned the gloves, removed her face shield, then applied an N95 over her surgical mask, and reapplied her face shield. An interview was conducted with the DON during the above observation. She indicated CNA 4 did not perform hand hygiene after doffing her PPE when exiting Residents C's and D's room, and all trash receptacles were located outside of the rooms, but could be placed inside instead. During the tour, CNA 5 was observed walking		Corrective actions put into place due to deficient practices as listed above: • Infection Preventionist provided education on hand hygiene, donning and removing personal protective equipment, standard precautions and handling of soiled linen on the following dates to each department: o Nursing staff- 11/17/21 o Dietary, Life Enhancement, Environmental Services, Maintenance and Administrative staff-11/18/21 • Post test for Hand Hygiene and Standard Precautions distributed to all department directors to give to all staff on 11/18/21. • Education regarding infection control policy and procedures and standard precautions including hand hygiene, donning and removing personal protective equipment, standard precautions and handling of soiled linen will be provided to each department monthly by the Infection Preventionist, or designee. Staff educated will be documented monthly and returned to the Infection Preventionist. System Changes: -Infection Preventionist has completed infection control rounds in yellow transmission-based areas. Immediate action was taken for the following: o Trash bins were moved from	

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	down the hallway towards a soiled linen bin. She was carrying white soiled linen, not contained, with her bare hands. When she reached the soiled linen bin, she placed the soiled linen into the bin. She then retrieved a bag and bagged the soiled linen from the bin with her bare hands and placed it back into the bin. The DON asked CNA 5 why she was carrying soiled linen down the hallway. CNA 5 indicated it was because she ran out of bags. The DON informed her she should have left the soiled linen in the room, came back to get a bag, and then returned to the room. CNA 5 agreed. The Hand Washing policy was provided by the DON on 11/15/21 at 2:30 p.m. It read, "Observe standard precautions or appropriate infection control measures. Follow the Centers for Disease Control (CDC) guidelines for hand washing." The Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 CDC guidelines was provided by the DON on 11/15/21 at 2:30 p.m. It read, "Donning (putting on the gear): ...1. Identify and gather the proper PPE to don...2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown...4. Put on NIOSH-approved N95 filtering a facepiece respirator or higher...5. Put on face shield or goggles....6. Put on gloves....7. HCP [Health care personnel] may now enter patient room. Doffing (taking off the gear): ...1. Remove gloves....2. Remove gown....3. HCP may now exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles...6. Remove and discard respirator...7. Perform hand hygiene after removing the respirator/facemask...."		outside resident room to inside resident room at exit to ensure staff are removing personal protective equipment as close to exit as possible and to ensure no transmission is possible to hallway. This was completed by end of day 11/15/17. o Standing alcohol-based hand sanitizing station was relocated in The Courtyards breezeway and placed directly under keypad prior to entering The Courtyards. This was completed on 11/15/21. o Trash bin in The Courtyards breezeway was removed and placed directly inside the doors of The Courtyards so staff are removing personal protective equipment immediately prior to exit of The Courtyards. This was completed on 11/17/21. System Changes continued: Hand sanitizer has been placed at all personal protective equipment stations- 11/17/21 o Purchasing notified on 11/17/21 of need to inquire regarding wall mounted hand sanitizing stations to be placed in the Healthcare Center and The Courtyards to increase employee compliance with hand hygiene. o Purchasing ordered wall mounted hand sanitizing stations for the Healthcare Center and The Courtyards on 11/19/21. o Director of Maintenance notified of arrival of wall mounting hand sanitizing stations on 11/23/21.	

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	The Laundry policy was provided by the DON on 11/15/21 at 2:30 p.m. It read "Place all soiled linens in a clear plastic bag, secure, apply colored dot, and place in the soiled linen hamper."		o Policy of handling soiled linen updated on 11/21/21 and reviewed with nursing staff during weekly huddle on 11/23/21. • Success Evaluation: How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance measures will be put into action for the following: 410 IAC 16.2-3.1-18 Affected: 16-18-5-1 410 IAC 16.2-5-12 (b) (1-4) • Wall mounted sanitizing stations arrived on 11/23/21. Director of Maintenance notified of arrival of hand sanitizing stations and installed in The Courtyards on 12/2/21. NOTE: 2nd case of sanitizing stations have been ordered; and set to arrive 12/1/21. These will be mounted in the Healthcare Center upon arrival to facility and after The Courtyards sanitizing wall mounts have been mounted. Post- test for Hand Hygiene and Standard Precautions distributed to Department Directors on 11/22/21. Tests will be completed by all staff and returned to Infection Preventionist, or designee. Infection Preventionist, or designee, will grade all tests by 12/4/21. • Expectation will be that all staff will pass test with 90%. Those that	

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			do not pass with minimum of 90% will receive re-education from Infection Preventionist, or designee. • Nursing Leadership and the Infection Preventionist, or designee, will provide increased focused efforts on infection control practices with specific focused infection control surveys to ensure compliance. • Infection control observations and surveillance will be increased to daily x 4 weeks (beginning on 11/17/21-12/15/21) and then weekly thereafter. This will be performed to determine if staff are following appropriate standard and transmission- based precautions during periods of heightened surveillance and during times when a resident is placed in yellow or red zone for COVID-19 transmission- based precautions. The infection control observations will be reviewed monthly during Quality Assurance meetings. • The Infection Preventionist, or designee, will randomly select employees from the following departments: Nursing, Environmental Services, Dietary, Maintenance, Life Enhancement and Administrative staff. • The Infection Preventionist, or designee, will observe for appropriate implementation of standard and transmission-based precaution, including hand hygiene, respiratory/cough	

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			etiquette and appropriate donning and removing of personal protective equipment. Observations will be recorded on the Infection Control Observation log and recorded as pass or fail. Failures will be recorded on a validation checklist to review findings with the employee and provide the employee with corrective action as needed. • The Infection Preventionist provided education to all departments on 11/17/21 and 11/18/21 regarding proper containment of soiled personal protection equipment. All staff and departments will be responsible for ensuring soiled personal protection equipment is properly placed in trash receptacle and appropriately covered so nothing is exposed. Trash will be emptied upon filling. • The Infection Preventionist, or designee, and members of Nursing Leadership will complete observation and surveillance during the infection control observations and surveillance schedule. This will be daily x 4 weeks (beginning 11/17/21-12/15/21) and then weekly thereafter. The infection control observations will be reviewed monthly during Quality Assurance meetings.	

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