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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 00 B. WING	11/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

(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 8, 2021 Facility number: 000226 Provider number: 155333 AIM number: 100267730 Census Bed Type: SNF/NF: 74 SNF: 6 Total: 80 Census Payor Type: Medicare: 11 Medicaid: 57 Other: 12 Total: 80 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 15, 2021.	F 0000		
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			

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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	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 must prohibit employees with a communicable disease or infected skin			

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	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 and interview, the facility failed to properly prevent and/or contain COVID-19 for 2 of 2 residents observed for care, 1 of 1 meal services observed and 3 of 6 employees observed. Used PPE (personal protective equipment) was not stored properly and hand hygiene was not performed after removing PPE. (Resident 2, Resident 3, Employee 1, CNA 2, CNA 3) Finding includes: 1. On 11/8/21 at 11:52 A.M., Employee 1 indicated she was going to prefer a COVID-19 test for Resident 2. Employee 1 gathered her paperwork and stood outside Resident 2's room. Employee 1 donned a clean isolation gown, removed her face shield and set it on the	F 0880	F880 Directed POC The directed plan of correction (DPOC) is to serve Paoli Health and Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Paoli Health and Living's or its management company that the allegation contained in the survey report is true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. **The facility respectfully requests desk review for the**	11/30/2021

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	isolation cart, removed her N95 mask and set it on top of the face shield, donned a clean N95 and a clean face shield. No hand hygiene was observed. Employee 1 donned gloves and touched used N95 mask that was sitting on the isolation cart. Employee 1 obtained the biohazard bag with the specimen collection container inside it and entered the room. After the test was complete, Employee 1 opened the door to Resident 2's room and placed the biohazard bag on top of the isolation cart. Employee 1 removed her gown and gloves at the door to the resident room. Employee 1 removed her face shield and N95 mask and placed them in the trash receptacle. Employee 1 performed hand hygiene and placed the used face shield and N95 mask on top of the isolation bin and put them back on. Employee 1 grabbed the biohazard bag and walked down the hall. No hand hygiene was observed. 2. On 11/8/21 at 12:15 P.M., CNA 2 was observed to donn and doff personal protective equipment. CNA 2 donned a clean isolation gown. CNA 2 removed her face shield and placed it on top of the isolation cart. CNA 2 removed her N95 and placed it on top of the face shield. CNA 2 donned a clean face shield and N95 mask. No hand hygiene was observed. CNA 2 donned clean gloves and entered Resident 3's room. CNA 2 removed her gown and gloves at the exit to the room. CNA 2 picked up a bag of soiled washable gowns from inside the resident room. CNA 3 removed her face shield and N95 and placed the old face shield and N95 on. No hand hygiene was observed. CNA 2 walked down the hall and opened the door to the soiled utility room and placed the washable gowns in the soiled utility room. CNA 2 then performed hand hygiene with alcohol based hand rub.		**following citation.** **F880 Infection Prevention and Control** **S/S E** **I. The Corrective actions to be accomplished for those residents found to have been affected By the Practice.** There were no negative outcomes by the alleged practice. The staff members found to have deficient practices were immediately educated, with return demonstration, on proper hand hygiene and PPE practices and storage. II. **The Facility will identify other residents that may potentially be affected by practice.** All other residents have the potential to be affected by the alleged deficient practice. Rounds were made to ensure staff were storing PPE appropriately and preforming hand hygiene. III. **The Facility will put into place the following systemic changes to ensure that the practice does not recur.** · CMS-CDC Fundamentals of covid-19 Prevention Training Self-Assessment Questionnaire completed indicating need for “Hand Hygiene and PPE Training” which was implemented for facility staff (Attachment A). · Root cause Analysis RCA with consultant infection	

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	3. On 11/8/21 at 12:39 P.M., CNA 2 was observed to be passing the noon meal trays. CNA 2 prepared to enter an isolation room. CNA 2 donned a clean isolation gown. CNA 2 opened a new N95 and obtained a new face shield from the isolation cart. CNA 2 removed her face shied and N95 and placed them on the hand rail in the hallway. CNA 2 was observed to donn a clean N95 mask, face shield, and gloves. CNA 2 picked up the meal tray from on top of the isolation cart and entered the resident room. No hand hygiene was observed. 4. On 11/18/21 at 12:42 P.M., CNA 3 was observed to be passing the noon meal trays. CNA 3 obtained a meal tray for a resident on isolation precautions. CNA 3 placed the meal tray on the isolation cart. CNA 3 obtained a clean face shield and N95 mask. CNA 3 removed her face shield and N95 mask and placed it on hand rail in the hallway. CNA 3 donned the clean N95 mask and face shield. No hand hygiene was observed. CNA 3 donned and isolation gown and gloves. CNA 3 entered the resident room. CNA 3 doffed her gown, gloves, face shield, and N95 mask at the entrance to the room. No hand hygiene was observed. CNA 3 donned the used N95 mask and face shield. CNA 3 performed hand hygiene with alcohol based hand rub. On 11/8/21 at 12:24 P.M., RN 1 indicated that she only placed a clean N95 and face shield on when exiting the room of a resident on isolation for exposure to COVID-19. CNA 2 indicated that she did not want to take any germs into the room of a resident on isolation so she put on a clean face shield and N95 to enter the resident room and then placed the used face shield and		Preventionist, including input from the facility Medical Director/DON/IP was completed (Attachment B). · Consultant Infection Preventionist educated IDT/Leadership team on the Indiana State Department of Health COVID-19 LTC Facility infection Control Guidance Standard Operating Procedure and hand hygiene utilizing CDC and WHO guidelines and proper PPE procedure and storage (attachment C). · All staff educated regarding procedure and storage of PPE, and preforming hand hygiene (Attachment D) IV. The facility LTC Infection control Self-assessment was reviewed with consulting infection Preventionist resulting in an updated LTC Infection control assessment being completed with input from the Consultant IP/Medical Director and DON (Attachment E). **V. The facility will monitor for the corrective action by implementing the following measures.** · The DON or designee will observe staff to ensure PPE is stored appropriately daily for 6 weeks then weekly for 8 weeks, then monthly for 9 months for a	

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	N95 back on after exiting the room. RN 1 indicated that herself and CNA 2 usually worked the 200 unit together. On 11/8/21 at 2:43 P.M., the DON indicated that on every isolation door there is information on how to donn and doff PPE properly. The DON indicated facility staff only needed to change their N95 mask and face shield for residents in isolation with confirmed COVID-19 infection but not for residents on isolation precautions for exposure to COVID-19. The DON indicated that if facility staff were removing their N95 mask with the intent to use them again there were paper bags they could place them in. The DON further indicated that facility staff should take off all of their PPE, perform hand hygiene, and put on clean PPE prior to entering a resident room. The DON further indicated hand hygiene should be completed after removing PPE when exiting an isolation room. On 11/8/21 at 2:51 P.M., in response to a request for facility policy related to donning and doffing PPE, the DON indicated that the facility followed the CDC guidance for donning and doffing. 3.1-18(b)(1)		total of 12 month of monitoring using the quality Improvement Tool F-880 audit tool. (Attachment F). · The DON or designee will observe to ensure staff are preforming hand hygiene appropriately daily for 6 weeks then weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring using quality improvement tool F-880 audit tool. (Attachment G) The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **VI. Plan of correction completion date.** Date of compliance: November 30, 2021 The Administrator will be responsible for ensuring the facility complying by the date of compliance listed. The plan of correction is to serve as Paoli Health and Living's credible allegation of compliance.	