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	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCLAVE SENIOR LIVING AT SAXONY, THE	12950 TALBLICK STREET FISHERS, IN 46037

(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 State Residential Licensure Survey. Survey dates: April 19, 20, and 21, 2021 Facility number: 013945 Residential Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 26, 2021	R 0000		
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill			

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

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	in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted at least quarterly on each shift for 66 of 66 residents. Findings include: The fire drill logs for the first, second, third and fourth quarters of 2020 were reviewed on 4/20/21 at 2 p.m. The facility conducted fire drills as follows: 1st quarter: Shift 1--1/29/20 at 1:50 p.m. and 3/5/21 at 12 p.m. Shift 2--2/19/20 at 4 p.m. and 3/27/20 at 3:25 p.m. Shift 3--2/26/20 at 6 p.m. 2nd quarter Shift 1--4/23/20 at 2:30 p.m. Shift 2--6/30/20 at 6 p.m. Shift 3--none 3rd quarter shift 1--none shift 2--none Shift 3--7/10/20 at 5 a.m. 4th quarter shift 1--12/11/20 at 1 p.m. shift 2--10/30/20 at 4:p.m. Shift 3--11/27/20 at 6 a.m. There was documentation in the fire drill log of drills being conducted on 5/12/20 and 8/14/20, however the fire drill sheets did not indicate the	R 0092	**-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Director of Maintenance or Designee will conduct a monthly fire drill while providing education to the staff and residents on May 5, 2021. A fire drill schedule will be created by the Director of Maintenance and reviewed monthly by the Executive Director for compliance. **-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The deficient practice had the potential to affect all residents residing in the community. See above for corrective action. **-What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Fire Drill Policy was reviewed by the Director of Maintenance on May 5, 2021.	05/07/2021

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	time of day these drills were conducted. During an interview on 4/20/21 at 2:19 p.m., the Maintenance Supervisor (MS) indicated fire drills should have been conducted on each shift during for each quarter of 2020 nor could he find any further fire drills performed during 2020.		The Director of Maintenance has created a calendar as to which drills will be conducted. This calendar will be shared with ED and/or designee who will monitor monthly to ensure that drills occur per the schedule and in accordance with the regulations. **-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; and** The Director of Maintenance will schedule and facilitate drills while the Executive Director or Designee will monitor that fire drills occur in accordance with the regulations. The Director of Maintenance will be responsible for completing the drills, and the process will be reviewed monthly for compliance by the Executive Director. **By what date the systemic changes will be completed.** Changes will be completed by 5-7-21.	
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made			

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	for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation and interview, the facility failed to ensure outside dumpster lids were closed. This had a potential to affect 66 of 66 residents that reside in the facility. Findings include: An observation was made with the Maintenance Supervisor of the outside dumpsters on 4/21/21 at 1:48 p.m. There were 3 dumpsters observed inside a opened fenced area. The dumpsters contained boxes and trash bags in them. The top lids to the dumpsters were opened. A 4th dumpster was located outside of the fenced area that was full of trash bags. The ground around the dumpster had banana peels lying beside it. An interview was conducted with the Maintenance Supervisor on 4/21/21 at 1:50 p.m. He indicated all 4 of the dumpsters should be sitting inside the fenced area with the doors to the fence closed. He was unsure why the 4th dumpster had been rolled out of the fence area. The top lids on the dumpsters were unable to be closed due to the tightness of the fenced area housing all 4 of the dumpsters.	R 0155	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All residents have the potential to be affected by the deficient practice. There were no residents noted to be negatively affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Sanitation and Safety Standards, specific to the closure of dumpster lids has been reviewed and signed off with all team members responsible for trash disposal on May 7, 2021. The education was provided by the Director of Maintenance. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Director of Maintenance and Director of Food and Beverage or Designee will monitor, per the schedule below, that the dumpster areas are clean and that lids are closed at all times. A daily work	05/09/2021

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			order will be checked off by the Director of Maintenance or Designee ensuring compliance. **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; and** The Director of Maintenance or Designee will be responsible for inspecting the trash area for cleanliness/lid compliance and maintaining a log documenting compliance daily for a period of two weeks, then weekly for a period of six months, and then monthly thereafter. **By what date the systemic changes will be completed.** May 9, 2021	
R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation and interview, the facility failed to ensure all food is served at safe and appropriate temperatures on the Memory Care unit for 20 of 20 residents residing on Memory Care. Findings include: 1. An observation, on 4/21/21 at 11:55 a.m., of MCM (Memory Care Manager) who completed the task of obtaining food temperatures for the food on the steam table, indicated the internal temperatures of the food being served as:	R 0272	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All 20 memory care residents have the potential to be affected by the deficient practice. There were no residents noted to be negatively affected. At the time of the deficiency, the tuna salad and mashed potatoes were removed	05/07/2021

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	mashed potatoes- 127° F meat loaf-141.8° F mixed vegetables- 159.6° F fish planks- 166.6° F french fries- 172.9° F chicken tenders- 155.1° F tuna salad on croissant- 70.8° F The following foods were not at safe and appropriate temperatures: mashed potatoes, meat loaf, and tuna salad. The tuna salad sandwich was first served at 11:59 a.m. The mashed potatoes and meat loaf were on a separate plate for one resident and that plate was served at 12:11 p.m. An interview with DFB (Director of Food and Beverage), on 4/21/21 at 1:16 p.m., indicated the mashed potatoes and tuna salad should not have been served since they were not at the appropriate temperature. The Indiana Retail Food Manual states, "foods not covered under sections 182 and 183 of this rule that are cooked for hot holding shall be cooked to an internal temperature of one hundred thirtyfive (135) degrees Fahrenheit...Sec. 187. (a) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under section 193 of this rule, potentially hazardous food shall be maintained as follows: (1) At one hundred thirty-five (135) degrees Fahrenheit or above, except that roasts cooked to a temperature and for a time specified under section 182(b) of this rule or reheated as specified in section 188(e) of this rule may be held at a temperature of one hundred thirty (130) degrees Fahrenheit. 44 (2) At a temperature specified in the following: (A)		and not served. Team members were immediately re-educated on appropriate temperatures and recording. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All foods transported to Memory Care are to be temped and logged by the cooks before transport and temped and logged again by Memory Care staff upon arrival. Any hot foods under the proper temperature of 135 degrees Fahrenheit will be re-heated and re-temped prior to being served to the resident. The Director of Food and Beverage or Designee will be responsible for ensuring the Temperature Logs are maintained. Staff involved in meal service will be in-serviced on proper food handling temperatures and recording on May 6, 2021. **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; and** A monitoring tool will be completed daily and monitored 5 days weekly for two weeks, weekly for 4 weeks, then monthly education will be ongoing. This tool will be maintained by the Executive Director..	

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	At forty-one (41) degrees Fahrenheit or less."		**-By what date the systemic changes will be completed..ie., what quality assurance program will be put into place.** May 7, 2021	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to kitchen staff not wearing face masks appropriately, open and/or undated food in the coolers and freezer, improper storage of food in freezer, not mixing sanitation bucket solution correctly, unclean meat slicer, an ice cream container lid on the floor and heavy accumulation of grease on the grill and stove. (Main Kitchen) Findings include: An observation was made on 4/21/21 at 9:31 a.m. of 3 out of 4 kitchen staff members in the kitchen not wearing their face masks appropriately. KS (Kitchen Staff) 7, KS 8 and KS 9 had their face masks pulled down so that their nose and mouth was uncovered. KS 7, at the time of the observation, was cutting a pineapple at the prep station while KS 8 and 9 were standing at the same prep station. All were less than 6 feet apart. During the Brief Kitchen Sanitation Tour on 4/21/21 at 9:31 a.m. with KS(kitchen staff) 6 the following was observed:	R 0273	**have been affected by the deficient practice;** All residents had the potential to be affected, however no negative outcome was noted. At the time of survey: Items without dates were disposed of. Team members were immediately in-serviced on the proper wearing of masks. The sanitizer buckets were poured out and re-mixed. The meat slicer was cleaned. Ice cream lid was properly disposed of. Stovetop was cleaned. **-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents had the potential to be affected by the deficient practice.	05/07/2021

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	1. In the condiment cooler: -an opened container of cottage cheese without an opened date - 13 jars of key lime, unlabeled and undated -13 jars of chocolate mousse, unlabeled and undated 2. In the main cooler: -two large clear plastic containers of cole slaw unlabeled and undated -an opened bag of salad mix, unlabeled and undated -an opened bag of shredded cheese, unlabeled and undated -a large metal bowl with plastic wrap labeled as "mousse", undated -a multi-shelf cart with 3 large metal pans identified as chicken gravy, beef gravy and mashed potatoes, all were unlabeled and undated -another multi-shelf cart with a plastic container containing cut onions, unlabeled and undated 3. In the freezer, 3 boxes of food were stored on the floor of the freezer. One box contained frozen pizza dough, the second contained whole chicken fryers, and the third box contained french fries. 4. An observation of KS 7 was made on 4/21/21 at 10:25 a.m. KS 7 was wiping down dining tables. When asked to check his sanitation bucket for adequate sanitizer level, he indicated, he did not know how to check for adequate dilution of sanitizer. He further stated, he places water, a yellow solution, and some of another solution into a bucket and uses that to clean the tables. An interview with KS 8 was conducted on 4/21/21 at 10:30 a.m. KS 8 indicated, the way to		**-What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Team members were educated and documented understanding of proper mask wearing, food storage, sanitizer use concentration, cleaning specific to the meat slicer and cleaning specific to the oven on May 4, 2021. This education was presented by the Regional Food and Beverage Director **-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; and** An auditing system has been implemented to include monitoring daily for 5 days x 2 weeks, weekly x 4 weeks, then monthly until compliance is maintained. Auditing will be monitored by the Director of Food and Beverage or Designee. **-By what date the systemic changes will be completed.** May 7, 2021.	

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	check for the correct dilution of sanitizer was to check using color changing strips, which when dunked in the bucket mixed with sanitizer, will change colors which then are referenced to the strip bottles color chart and indicated the level of sanitizer in the bucket. KS 8 performed the strip test on two sanitizer buckets which were currently being used to wipe down dining tables. The strips indicated 0 and 1.95 ppm (parts per million). KS 8 referenced the readings she received indicated there was not enough sanitizer in the buckets as the strip color should be more in the green. 5. The meat slicer was covered during the kitchen tour. When uncovered , it was observed to have pieces of meat on the blade and the tray below the blade. It appeared to be dirty still from the previous day. An interview with KS 9 conducted on 4/21/21 during the Kitchen tour, indicated, he used it on 4/20/21 to slice meat for the lunch service. He stated, "I just put the cover on it today, meaning to clean it, but haven't gotten to it yet". 6. There was a lid from a container of ice cream on the floor located next to empty boxes 7. There was a heavy accumulation of grease and food debris on top of the stove and on the grates. An interview with DFB (Director of Food and Beverage) conducted on 4/21/21 at 1:16 p.m., indicated, food should be labeled and dated when opened, food should not be stored on the floor in the freezer, and the facility does not use quat for the sanitation buckets but rather a mixture of two different solutions for the sanitation buckets.			

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	The Indiana Retail Food Manual states, "Sec. 177. (a) Except as specified in subsections (b) and (c), food shall be protected from contamination by storing the food as follows: (1) In a clean, dry location. (2) Where it is not exposed to splash, dust, or other contamination. (3) At least six (6) inches above the floor. (4) In a manner to prevent overcrowding. (5) In packages, covered containers, or wrappings. (b) Food in packages and working containers may be stored less than six (6) inches above the floor on case lot handling equipment....Sec. 191. (a) Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on one (1) of the temperature and time combinations specified as follows and the day of preparation shall be counted as day one (1): (1) Forty-one (41) degrees Fahrenheit or less for a maximum of seven (7) days. (2) Forty-five (45) degrees Fahrenheit or between forty-one (41) degrees Fahrenheit and forty-five (45) degrees Fahrenheit for a maximum of four (4) days in existing refrigeration equipment that is not capable of maintaining the food at forty-one (41) degrees Fahrenheit or less if: (A) the equipment is in place and in use in the food establishment, and (B) the equipment is upgraded or replaced to maintain food at a temperature of forty-one (41) degrees Fahrenheit or less as specified in section 187(a)(2)(B)(ii) of this rule.			

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	(b) Except as specified in (d) and (e) of this section, refrigerated, ready-to-eat, potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a retail food establishment and if the food is held for more than twenty-four (24) hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in subsection (a) and: (1) the day the original container is opened in the retail food establishment shall be counted as day one (1); and (2) the day or date marked by the retail food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety."			
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview, and record review, the facility failed to ensure medications	R 0301	**-What corrective action(s) will be accomplished for those**	05/09/2021

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	stored in the medication carts were labeled with the resident's names and open dates of the medication for 2 of 2 medication carts observed. (Resident's 9, 38, 42, 43, 47, and 54) Findings include: 1. The clinical record for Resident 9 was reviewed on 2/20/21 at 11:00 a.m. The diagnosis for Resident 9 included, but was not limited to, chronic obstructive pulmonary disease (COPD). A physician order dated 1/29/21 indicated Resident 9 was to receive 2 puffs of budesonide-formoterol inhaler daily. 2. The clinical record for Resident 38 was reviewed on 2/21/21 at 11:30 a.m. The diagnosis for Resident 38 included, but was not limited to, open angled glaucoma. A physician order dated 2/8/21 indicated staff was to administer 1 drop of artificial tears in both eyes to Resident 38 as needed. A physician order dated 3/24/21 indicated staff was to administer refresh eye drops to Resident 38 three times a day. 3. The clinical record for Resident 43 was reviewed on 2/21/21 at 12:00 p.m. The diagnosis for Resident 43 included, but was not limited to, type 2 diabetes mellitus. A physician order dated 8/20/20 indicated Resident 43 was to receive 1 drop of artificial eyes in each eye twice a day. 4. The clinical record for Resident 42 was reviewed on 2/21/21 at 12:15 p.m. The		**residents found to have been affected by the deficient practice;** An audit was completed on May 3, 2021 for residents 9, 38, 42, 47 and 54, and no further medication labeling errors were identified at that time. **-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All medication carts were audited May 4, 2021 for proper labeling and storage. Any instances of improper labeling or storage were immediately addressed by the Director of Nursing. **-What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Care team members responsible for medication administration, including licensed nurses and QMA's, were provided education on proper labeling and storing medications on May 7, 2021. This education was provided by the Director of Nursing. **-How the corrective action(s) will be monitored to**	

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	diagnosis for Resident 42 included, but was not limited to, dry eye syndrome. A physician order dated 3/22/21 indicated Resident 42 was to receive one drop of refresh eye drops as needed for dry eyes. 5. The clinical record for Resident 47 was reviewed on 2/21/21 at 1:45 p.m. The diagnosis for Resident 47 included, but was not limited to, anxiety. A physician order dated 12/22/20 indicated Resident 47 was to receive 2 drops of systane Balance eye drops into the right eye once a day. 6. The clinical record for Resident 54 was reviewed on 2/21/21 at 3:30 p.m. The diagnosis for Resident 54 included, but was not limited to, ear impaction. A physician order 4/15/21 indicated Resident 54 was to receive 5 drops of carbamide peroxide ear drops in both ears twice a day for 10 days due to wax impaction. An observation was made of the 2nd floor medication cart with Qualified Medication Aide (QMA) 3 on 4/21/21 at 10:15 a.m. The top drawer of the medication cart was observed with medications stored in it. A capped inhaler labeled bedesmoide/formeterol fumerate was located in the back drawer. There was no resident's name on the inhaler. QMA 3 indicated at that time the inhaler belonged to Resident 9 and had not been used. The inhaler was delivered from the pharmacy in a box with a label that included the resident's name, but it was thrown away. The drawer also contained bottles of eye drops. There were opened eye drops labeled artificial tears,		**ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Ongoing cart review to identify proper labeling and storage will be maintained and monitored by the Director of Nursing or Designee who will complete a weekly audit for 4 weeks and monthly for 4 months thereafter for compliance. **-By what date the systemic changes will be completed.** May 9, 2021	

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	prednisone, and refresh tears for Resident 38. QMA 3 reported the eye drops were on hold, but they had been opened and used. There were no open dates on Resident 38's artificial tears, prednisone, and refresh tears eye drops. There was an observation of an opened bottle labeled prednisone eye drops and artificial tears eye drops for Resident 43 in the drawer. There were no open dates written on the bottles. The drawer contained Resident 42's eye drop opened and labeled prednisone and artificial tears. There were no open dates on either eye drop bottles. QMA 3 indicated the prednisone and artificial tears had been in the cart for a couple of weeks, but she had never administered them to Resident 42. All medications stored in the cart should be labeled with the resident's name, and the open date should be written on them after they are opened. An observation was made of a medication cart in the Memory Care with the Memory Care Manager on 4/21/21 at 10:44 a.m. The top drawer was observed with an opened carbomade peroxide ear drops for Resident 54. There was no opened date on the bottle. The drawer also contained an opened bottle of systane balance eye drops for Resident 47. The eye drops were opened with no open date on the bottle. An interview was conducted with the Memory Care Manager on 4/21/21 at 10:46 a.m. She indicated open dates should be placed on the medication after they are opened.			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution.			

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	(3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure a transfer form was utilized when a resident was transferred to the hospital for 1 of 2 closed residents' records reviewed. (Resident 64) Findings include: The clinical record for Resident 64 was reviewed on 2/19/21 at 2:35 p.m. The diagnoses for Resident 64 included, but were not limited to, Alzheimer's Disease. A nursing note dated 12/29/20 indicated "Resident [64] was presented with s/s [sign and symptoms of extreme weakness, unable to talk, and could not keep her eyes open. [name of Resident 64's family] and resident (sic) doctor..notified by staff, and EMT [Emergency Medical Technician] called, Resident transferred to [name of hospital emergency room]..." The clinical record for Resident 64 did not include a transfer form that was used for the resident when she was transfered to the hospital on 12/29/20.	R 0354	**-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No adverse consequences were identified as a result of Resident #64's transfer to the Emergency room without a Transfer Form. **-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The DON reviewed the past 45 days for compliance with transfer sheets available upon transfer. The process of sending the Transfer Document with every resident who leaves the community has been reviewed. The DON will concurrently review every transfer out to assure compliance. If the DON or	05/09/2021

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	An interview was conducted with the Director of Nursing on 4/20/21 at 2:54 p.m. She indicated she was unable to locate one for Resident 64's transfer to the hospital on 12/29/20.		Designee note non-compliance will address immediately. **-What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** An education for Care Team members took place on completion of Transfer Forms and Discharge Documentation on May 7, 2021 and was conducted by the Director of Nursing. **-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; and** A review/audit of transfers/discharges will be completed by the Director of Nursing or Designee weekly. The audit will be completed weekly for 4 weeks and monthly for 6 months thereafter. **-By what date the systemic changes will be completed.** May 9, 2021	
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			

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	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 observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 by not ensuring staff wore face masks that were pulled up covering their noses and conduct adequate monitoring for signs and symptoms of COVID-19 for 5 of residents reviewed for infection control. (Resident's 1, 7, 9, 41 and 52) Findings: 1. An observation of the Memory Care unit was made on 4/20/21 at 10:42. CNA(Certified Nursing Assistant) 10 and CNA 11 were conducting an activity with memory care residents. At the time of the observation, CNA 10 and 11 had their facemasks pulled down below their noses, leaving their noses exposed. They were asked to wear their facemasks in the appropriate manner. An observation was made on 4/20/21 at 10:46 a.m., of CNA 11 continuing with the activity on the Memory Care unit. CNA 11's mask was again below her nose. She then bent down over a resident, pulled her mask all the way down to below her chin, and conversed with the resident. 2. An observation was made on 4/21/21 at 9:31 a.m. of 3 out of 4 kitchen staff members in the kitchen not wearing their face masks	R 0407	**-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 1, 7, 9, 41 and 52 were found to have no adverse reaction as a result of the deficient practice. **-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Team Members identified not properly wearing masks have received a formal Corrective Action which has been placed in their prospective Employee Files. A Nursing Observation has been added to the Medication Administration Record adding signs/symptoms as part of the monitoring process. **-What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	05/07/2021

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	appropriately. KS (Kitchen Staff) 7, KS 8 and KS 9 had their face masks pulled down so that their nose and mouth was uncovered. KS 7, at the time of the observation, was cutting a pineapple at the prep station while KS 8 and 9 were standing at the same prep station. All were less than 6 feet apart.3. The clinical record for Resident 9 was reviewed on 2/20/21 at 11:00 a.m. The diagnosis for Resident 9 included, but was not limited to, chronic obstructive pulmonary disease (COPD). 4. The clinical record for Resident 41 was reviewed on 2/20/21 at 10:00 a.m. The diagnosis for Resident 41 included, but was not limited to, congested heart failure. 5. The clinical record for Resident 7 was reviewed on 2/19/21 at 3:00 p.m. The diagnosis for Resident 7 included, but was not limited to, dementia. 6. The clinical record for Resident 1 was reviewed on 2/19/21 at 1:30 p.m. The diagnosis for Resident 1 included, but was not limited to, hypertension. 7. The clinical record for Resident 52 was reviewed on 2/19/21 at 2:30 p.m. The diagnosis for Resident 52 included, but was not limited to, dementia. The clinical records for Resident's 1, 7, 9, 41, and 52 did not have documented daily monitoring of signs and symptoms of COVID-19. An interview was conducted with the Director of Nursing (DON) on 4/19/21 at 11:03 a.m. She indicated the staff were taking the residents' vitals that included temperatures. If a resident		**practice does not recur;** All team members were educated on the proper wearing of masks on May 5, 2021. Monitoring for signs/symptoms of COVID have been added to the Daily Vital Tasks. **-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; and** A shift audit will be completed by each Department Manager for proper wearing of masks and monitoring symptoms. This audit will take place daily beginning May 7 and continue for daily for 10 days and then compliance checks will be completed weekly for 6 weeks. Any violations will result in Corrective Action. An audit will be completed by the Director of Nursing for completion of signs/symptoms of COVID. The audit will take place beginning May 7, will take place daily for 10 days and then weekly compliance checks will be ongoing. **-By what date the systemic changes will be completed.** May 7, 2021	

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	developed a sign or symptom of Covid, at that time the resident would be placed in isolation and monitored. The Indiana Department of Health's dashboard indicated Hamilton county's COVID-19 positivity rate for the week of 4/19/21 was 5.45%. The Indiana State Department of Heath "Guidance for out of hospital facilities" dated 1/5/21 indicated "...that elderly patients/residents may not encounter fever with COVID-19..." The Indiana State Department of Health Standard Operating Procedure dated 11/22/20 indicated "..Prevent the introduction of COVID-19 into the facility..Assess residents' symptoms of COVID-19 infection upon admission to the facility, and daily during this pandemic..Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath or difficult breathing, fatigue, muscle or body aches, headache, new loss or taste of smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. Prevent the spread of COVID-19 within your facility.." The COVID-19 Community Room Programming policy was provided by Concierge 10 on 4/20/21 at 2:00 p.m. It indicated "...Policy. To foster resident engagement and overall health of [name of corporation] Residents, will organize appropriately distanced, safe activities of limited attendance in its Community Rooms...4. Infection control measures for the community apply to events, classes, and activities in the Community Rooms...a. All residents and team			

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	members participating must wear facemasks covering their noses and mouths outside of their apartments, into the Community Rooms and throughout the event, class or activity..."			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure residents had an annual health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage for 1 of 5 residents reviewed. (Resident 1) Findings include: A clinical record review for Resident 1 was conducted on 4/20/21. Resident 1's diagnoses included, but not limited to, macular degeneration, hypothyroidism, and hypertension. The clinical record for Resident 1, reviewed on 4/20/21 at 9:35 a.m., indicated there was no physician signed annual health statement stating the resident was free from tuberculosis in an infectious stage. Interview with the Director of Nursing (DON) on 4/21/21 at 3:37 p.m. indicated, she could not locate an annual health statement for Resident 1.	R 0409	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Annual Health Statement for Resident #1 revealing resident was “free from TB in an infectious state” was provided by the physician on April 22, 2021. **-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** An audit of Resident Clinical records, specific to the review of Annual Health Statements was conducted by the Director of Nursing on May 7, 2021. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient**	05/07/2021

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			practice does not recur; The DON or Designee will ensure any missing Annual Health Statements are reviewed, signed and returned by the physician and placed on the chart. This review occurred May 7, 2021. **-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; and** Resident Clinical records, specific to review of Annual Health Statements will be audited during Service Plan review by DON or Designee. The DON or Designee will ensure any omitted Annual Health Statements are reviewed, signed and returned by the physician. The audit will be completed weekly for 4 weeks and monthly for 6 months thereafter. **-By what date the systemic changes will be completed.** May 7, 2021	