STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155386	A. BUILDING _____ B. WING _____	**08/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAURELS OF DEKALB	**520 W LIBERTY ST BUTLER, IN 46721**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to report an allegation of abuse to the Indiana State Department of Health (ISDH) within 24 hours of the occurrence, for 1 of 1 residents. (Resident M) Findings include The clinical record of Resident M was reviewed on 8/20/2020. [DIAGNOSES REDACTED]. Assessment of the resident on admission to the facility included coughing or choking during meals or when swallowing medications, but no loss of liquids/solids from mouth when eating or drinking. The record failed to indicate an assessment of the resident after an alleged incident on 7/24/2020. During an interview on 8/20/2020 at 2:00 P.M., Employee 19 indicated she reported what she felt was inappropriate treatment. The report was made 3 or 4 weeks ago regarding a nurse's treatment of [REDACTED]. She indicated Resident M was having a hard time swallowing breakfast, and looked like she had milk running down her face; as if having trouble swallowing. LPN 22 (Licensed Practical Nurse) went to give medications crushed in applesauce. Resident M couldn't get it down, started coughing, had a gurgly cough, and was making vomiting noises. LPN 22 then placed tissues over her mouth and held it there, aggressively, and also berated the resident saying what, do you have to be a 2 year old to be on my hall? Resident M tried to back away and the wheelchair started to tip so Employee 19 caught it. After taking Resident M to the physical therapy room, she continued to cough and sounded like she had gurgling in her throat. Employee 19 indicated she just did what she could to be able to get her therapy done. She indicated she told the Occupational Therapist in the room with her and reported it to her supervisor and they both reported it to the Administrator. Nobody ever asked her anything more about it. She indicated she did not document anything about her observations. During an interview on 8/20/2020 at 2:46 P.M., the Administrator indicated she recalled Employee 19 came in and reported the incident. The Administrator indicated she would have documentation about the interviews, but had not reported it to ISDH. On 8/20/2020 at 3:28 P.M., the Administrator provided a typed up statement dated 7/24/2020. She indicated the statement was from her notes. In response to being asked why it was not on an incident report, and reported to ISDH, Administrator indicated because there was no injury. The facility policy titled Abuse Prohibitions, Investigation, and Reporting, revised 08/16, stated Policy: . Allegations of abuse/misappropriation and the investigative conclusion will be reported to the appropriate State regulatory agency, Law Enforcement agency, licensing, and/or certification board as required by State and Federal law. This Federal citation is related to Complaint IN 476 3.1-28(c)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to investigate an allegation of abuse to 1 of 1 residents. (Resident M) Findings include The clinical record of Resident M was reviewed on 8/20/2020. [DIAGNOSES REDACTED]. Assessment of the resident on admission to the facility included coughing or choking during meals or when swallowing medications, but no loss of liquids/solids from mouth when eating or drinking. The record failed to indicate an assessment of the resident after an alleged incident on 7/24/2020. Facility incident reports were reviewed from 7/1 through 8/20/20. These reports failed to indicate any alleged abuse or incidents toward Resident M. During an interview on 8/20/2020 at 2:00 P.M., Employee 19 indicated she reported what she felt was inappropriate treatment. The report was made 3 or 4 weeks ago regarding a nurse's treatment of [REDACTED]. She indicated Resident M was having a hard time swallowing breakfast, and looked like she had milk running down her face; as if having trouble swallowing. LPN 22 (Licensed Practical Nurse) went to give medications crushed in applesauce. Resident M couldn't get it down, started coughing, had a gurgly cough, and was making vomiting noises. LPN 22 then placed tissues over her mouth and held it there, aggressively, and also berated the resident saying what, do you have to be a 2 year old to be on my hall? Resident M tried to back away and the wheelchair started to tip so Employee 19 caught it. After taking Resident M to the physical therapy room, she continued to cough and sounded like she had gurgling in her throat. Employee 19 indicated she just did what she could to be able to get her therapy done. She indicated she told the Occupational Therapist in the room with her and reported it to her supervisor and they both reported it to the Administrator. Nobody ever asked her anything more about it. She indicated she did not document anything about her observations. During a follow up interview on 8/21/2020 at 10:18 A.M., Employee 19 indicated her interpretation of the nurse being aggressive was the nurse, in a forceful way was putting her fingers in the resident's mouth when the resident was trying to back away from her. The medication was in applesauce and the nurse placed it in her mouth. Employee 19 was next to the resident to the left and then got behind the resident's wheelchair when the chair started to tip back. she tried to dab some of the food off the resident's chin, but the nurse just went ahead and gave the meds. Employee 19 indicated she was pretty much able to see what the nurse was doing the entire time. Employee 19 was standing about 2 feet from the nurse and the resident. She indicated she could see everything until she moved behind the resident. The wheelchair was locked. She felt it was a violation of dignity for sure, but the nurse did not stop when the resident started to back away. Nobody ever followed up with her. A couple days later she talked to one of the nurses about Resident M complaining of new pain in her hip or leg- and the nurse said I can't really give her any medication if she can't swallow now, can I? During an interview on 8/20/2020 at 2:25 P.M., the therapy supervisor indicated whenever an allegation of abuse is reported, her role is to go straight to the Administrator, and they are to do the investigation together . She indicated that she remembered Employee 19 came to her and told her what happened, that the nurse administered medications in a not so kind manner, and Employee 19 had explained it in detail. Both she and Employee 19 went to the Administrator and reported it. The therapy supervisor indicated that the Administrator and Director of Nursing (DON) said they would handle it from there. The therapy supervisor indicated she was not aware that anyone else witnessed it. During an interview on 8/20/2020 at 2:46 P.M., the Administrator indicated that she recalled Employee 19 came in and spoke of LPN 22 being loud while talking and that Resident M was having difficulty eating her meal and food was coming from her mouth. She indicated she went straight to the LPN and asked about it. The LPN indicated she was wiping the resident's mouth off with the tissues, and the resident was pushing back. The LPN told the Administrator, Employee 19 was behind holding the wheelchair so it didn't tip back. Employee 19 was behind the resident and could not see her face. The Administrator indicated she would have documentation about the interviews. On 8/20/2020 at 3:28 P.M., the Administrator provided a typed up statement and indicated this was from her notes. In response to being asked why it was not on an incident report, the Administrator indicated because there was no injury.The Administrator indicated she did not interview other staff or residents in the immediate area, or to see if anyone had any concerns about rough treatment. A blank form titled Incident Report, #ADMIN005, was requested and received on 8/20/2020 and stated Type of Occurrence: . Type of Injury . H. None Identified The facility policy titled Abuse Prohibitions, Investigation, and Reporting, revised 08/16, stated Policy: . Reports of alleged abuse and/or misappropriation will be immediately reported to the Administrator and thoroughly

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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LAURELS OF DEKALB	520 W LIBERTY ST BUTLER, IN 46721

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) investigated. . III. Investigation: A. . When an incident of guest abuse is alleged, the incident must be reported to the charge nurse . B. Upon receiving a report of abuse, the charge nurse will immediately examine the guest. . The findings of the examination will be recorded in the medical record. (The physician is to be notified timely even if no injuries are observed.) C. . Facility employees who have been accused of guest abuse will be suspended until the results of the investigation have been reviewed by the Administrator. D. The Administrator will appoint a representative to investigate the incident. The Administrator will initiate the Investigation of Alleged Abuse, Mistreatment, or Misappropriation (Laurel form #ADMIN009) and make the appropriate notifications as outlined on the form. E. The Administrator or designee will coordinate an immediate investigation in accordance with the investigation guidelines in this policy. . A copy of the findings will be provided to the Administrator within five (5) working days of the occurrence of the incident. The investigation may consist of but is not limited to: 1. An interview with the person(s) reporting the incident 2. Interviews with any witnesses to the incident 3. An interview with the guest 4. A review of the guest's medical cal record 5. An interview with staff members (on all shifts) who had contact with the guest during the period of the alleged incident. 6. Interviews with the guest's roommate, family members, and visitors 7. Physical assessment of other potentially affected guests. 8. A review of all circumstances surrounding the incident. F. The charge nurse will complete the Incident Report (Laurel form #ADMIN005). . H. Upon receiving information concerning an allegation of abuse, . the Director of Nursing or Administrator will request that a representative of the Social Services Department or designee monitor the guest's feelings concerning the incident, as well as the guest's reactions to his or her involvement in the investigation. This Federal citation is related to IN 476 3.1-28(d)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow CDC guidance during a pandemic and implement an infection control program regarding allowing staff to work with signs and symptoms of COVID-19, and failing to monitor symptoms and ensuring proper isolation requirements and testing were initiated timely to prevent the potential spread of infection, for 11 of 125 staff reviewed for infection control prevention screening (Speech Therapist 3, CNA 5, CNA 6, CNA 7, Activity Staff 8, CNA 9, Housekeeping Staff 10, LPN 11, CNA 12, CNA 13 and CNA 14). On 8/7/20, Speech Therapist 3 had symptoms of COVID-19, and worked with Resident B, Resident D, Resident E, Resident F, Resident G, Resident H and Resident J. These residents later developed symptoms suggestive of COVID-19. Between the dates of 8/7/20 and 8/20/20, the facility had 29 symptomatic residents suggestive of COVID-19, 11 staff with symptoms, and 2 staff test positive for COVID-19. The facility also failed to ensure 2 of 7 residents were placed in droplet precautions in a timely manner (Resident F and Resident G). The immediate jeopardy began on 8/7/20 when Speech Therapist 3 continued to work despite having symptoms of COVID-19. Multiple staff continued to work in the facility while having COVID-19 symptoms, and residents began experiencing symptoms of COVID-19. The Executive Director, and Director of Nursing were notified of the immediate jeopardy on 8/19/20 at 4:52 P.M. The immediate jeopardy was removed on 8/24/20 at 2:13 P.M., but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy Findings include: 1. A review of COVID-19 Associate/Employee daily screening logs from 7/31/20 to 8/19/20, indicated staff continued to work with signs and symptoms of COVID-19 on the following days: On 8/3/20 CNA 6 reported cough and runny nose; On 8/6/20 CNA 7 reported vomiting; On 8/7/20 Speech Therapist (ST) 3 reporting having a sinus infection; On 8/10/20 CNA 9 reported having a sore throat and congestion; On 8/14/20 Housekeeper 10 reported having nasal congestion; On 8/16/20 LPN 11 reported having a cough, sore throat and headache; On 8/17/20 CNA 12 reporting having fatigue; On 8/17/20 CNA 13 reported having a cough, runny nose and chills; On 8/18/20 CNA 14 reported having cough and chills; On 8/18/20 CNA 7 reported having a sore throat; On 8/19/20 CNA 5 reported having body aches, runny nose and a headache; On 8/19/20 Activity Staff 8 reported having diarrhea. The facility's COVID-19 Associate/Employee daily screening log indicated to refer to CDC guidelines for signs and symptoms related to COVID-19. The signs and symptoms were posted as a flier for staff to observe while being screened. The flier indicated symptoms of COVID-19 included fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea. COVID-19 Screener/CNA 15 was interviewed on 8/19/20 at 10:59 A.M. During the interview COVID-19 Screener/CNA 15 indicated if staff had signs or symptoms, she would write them down on the screening log. She would then tell a nurse so they could talk with the staff having symptoms. The nurse would let the staff know if they could work. The nurse would then initial the screening log by the sign and symptoms section. COVID-19 Screener/CNA 15 had been screening staff since May. No staff had been sent home after reporting signs or symptoms of COVID-19 when being screened at the door. COVID-19 Screener/CNA 15 indicated no one had a temperature, and that is why they had not been sent home. Speech Therapist (ST) 3 was interviewed on 8/19/20 at 10:50 A.M. During the interview, ST 3 indicated she came to work on 8/7/20 with sinus pain, sinus drainage and congestion. She indicated she had a sinus infection on the screening log. ST 3 did not know what the facility did with screening information, but no one asked her for more information after she was screened. She indicated she wore a mask during her shift, but pulled it down to talk with Resident B who needed to see her mouth. She did not observe 6 foot distance when she pulled her mask down. The facility had educated her on signs and symptoms of COVID-19, but she did not think she was expected to do anything unless she was running a fever. Later, on 8/7/20, she developed a fever, cough, nausea, diarrhea, and continued to have sinus pain, sinus drainage and congestion. A Questionnaire for Employees Positive for COVID-19, dated 8/13/20, indicated ST 3 was tested for COVID-19 on 8/7/20 and positive results were relayed to the facility on [DATE] at 11:00 A.M. In an interview on 8/19/20 at 10:50 A.M., ST 3 indicated she had contact on 8/7/20 with Resident B. Information provided on 8/19/20 by LPN 17, indicated on 8/14/20, Resident B developed a temperature of 100.4, oxygen saturation of 75% on room air, and wheezes. Resident B was suspected of having COVID-19 and the facility was awaiting the results. In an interview on 8/19/20 at 10:50 A.M., ST 3 indicated she had contact on 8/6/20 and 8/7/20 with Resident D. Information provided on 8/19/20 by LPN 17, indicated Resident D began having dry heaves on 8/8/20 and had a temperature of 100.2 on 8/18/20. This resident was tested for COVID-19 on 8/20/20 and the facility was awaiting the results. In an interview on 8/19/20 at 10:50 A.M., ST 3 indicated she had contact on 8/6/20 and 8/7/20 with Resident E. ST 3 indicated she pulled her mask down so Resident E could see her mouth while talking. They were not distanced 6 feet apart at the time. Information provided on 8/19/20 by LPN 17, indicated Resident E developed wheezes on 8/16/20. This resident was tested for COVID-19 on 8/14/20 and the facility was awaiting the results. In an interview on 8/19/20 at 10:50 A.M., ST 3 indicated she had contact on 8/7/20 with Resident F. Information provided on 8/19/20 by LPN 17, indicated Resident F developed a cough and vomiting on 8/14/20. He developed a temperature of 99.2 and an oxygen saturation of 90% on 3 liters of oxygen on 8/17/20. In an interview on 8/19/20 at 10:50 A.M., ST 3 indicated she had contact on 8/7/20 with Resident G. Information provided on 8/19/20 by LPN 17, indicated Resident G developed vomiting on 8/16/20 and a cough on 8/19/20. This resident was tested for COVID-19 on 8/20/20 and the facility was awaiting the results. In an interview on 8/19/20 at 10:50 A.M., ST 3 indicated she had contact on 8/7/20 with Resident H. Information provided on 8/19/20 by LPN 17, indicated Resident H developed a temperature of 99.3, body aches and a headache on 8/19/20. This resident was tested for COVID-19 on 8/20/20 and the facility was awaiting the results. In an interview on 8/19/20 at 10:50 A.M., ST 3 indicated she had contact on 8/7/20 with Resident J. Information provided on 8/19/20 by LPN 17, indicated Resident J developed expiratory rhonchi on 8/18/20. This resident was tested for COVID-19 on 8/20/20 and the facility was awaiting the results. On 8/19/20, CNA 5 had symptoms of COVID-19, including body aches, runny nose and headache, and was observed working in the facility during the day shift on the 400 hall. On 8/13/20, CNA 5 had contact and worked with CNA 4, who tested positive for COVID-19 on 8/17/20. The Director of Nursing (DON) was interviewed on 8/19/20 at 3:31 P.M. During the interview the DON indicated staff are screened at the beginning of their shift. Staff had their temperature taken and were asked if they have any signs or symptoms of COVID-19 according to the CDC list. If they had a temperature greater than 100.0 they were removed from duty. The facility took staff temperatures at the end of their shift as well. If staff had signs or symptoms of COVID-19 they may not be sent home, unless they were having a temperature. The facility followed up and asked staff if the sign or symptom was normal for them, and if it was they could continue to work. The DON indicated she reviewed the screening sheets every couple of days. A temperature would be the biggest thing the facility was looking for when deciding if staff could continue to work or not. 2. Resident F's record review on 8/20/20 at 1:10 P.M., indicated [DIAGNOSES REDACTED]. On 8/14/20, the progress notes indicated Resident F had rhonchi in his upper lobes with diminished breath sounds in his bases. He had been eating a cookie, began to cough, and threw up. On 8/15/20, progress notes indicated a chest x-ray showed possible pneumonia. On 8/16/20, progress notes indicated he was weak and didn't have much energy. On 8/17/20, progress notes indicated the resident was started on [MEDICATION NAME] for pneumonia. He was also flushed, skin

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) was warm to touch, and lung sounds were diminished throughout the lungs. On 8/18/20, a progress not indicated the resident was declining, and he was struggling to breathe. On 8/19/20 a physician's orders [REDACTED]. On 8/19/20 Resident F respirations and heart rate ceased at 9:20 P.M. Resident F was not placed on isolation when he began having symptoms of COVID-19. 3. Resident G's record review on 8/20/20 at 1:30 P.M., indicated [DIAGNOSES REDACTED]. On 8/16/2020, the progress note at 7:58 P.M., indicated Resident G was weak, and threw up. She became unresponsive, but responded to interventions by the staff. Then at 8:48 P.M., the resident became unresponsive, oxygen saturation was 90% and the resident went to the hospital. On 8/17/20 at 5:04 A.M., the resident returned to the facility without being tested for COVID-19. Then at 2:51 P.M., the progress notes indicated Resident G had a cough, but did not have a temperature. After exposure to ST 3 on 8/7/20 and developing symptoms on 8/16/20, Resident G was not placed on precautions to prevent possible spread of COVID -19. On 8/19/20 at 5:50 P.M., a physician's orders [REDACTED]. A policy, dated 5/2020, was provided by the DON on 8/19/20 at 9:30 A.M., titled Coronavirus (COVID 19). The policy indicated .Care Givers. The facility will make all attempts to have consistent staff caring for guests/residents on precautions. Care givers and all facility staff will be screened as directed by CDC and CMS guidance. CDC guidance, Preparing for COVID-19 in Nursing Homes, dated as last updated 6/25/2020, indicated the following: .Remind HCP (Healthcare Personnel) to stay home when they are ill. If HCP develop fever (T?100.0oF) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace. Have a plan for how to respond to HCP with COVID-19 who worked while ill (e.g., identifying and performing a risk assessment for exposed residents and co-workers) . HCP with suspected COVID-19 should be prioritized for testing . Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19 CDC Guidance, Symptoms of Coronavirus, dated as last updated 5/13/2020, indicated the following: People with COVID-19 have had a wide range of symptoms reported - ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to [MEDICAL CONDITION]. People with these symptoms may have COVID-19: Fever or chills Cough Shortness of breath or difficulty breathing Fatigue Muscle or body aches Headache New loss of taste or smell Sore throat Congestion or runny nose Nausea or vomiting Diarrhea. This Federal citation is related to IN 286 3.1-18(a)