STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155600	A. BUILDING _____ B. WING _____	10/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MULBERRY HEALTH & REHABILITATION CENTER	**502 W JACKSON ST MULBERRY, IN 46058**

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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 maintain an infection prevention and control program when the facility did not designate a zone to cohort and manage the care of 8 of 8 residents under surveillance for COVID-19, four randomly observed staff members failed to wear appropriate personal protective equipment (PPE) (Activity Aide 11, Certified Nurse Aide 12, Housekeeper 8 and Laundry Aide 9), failed to put on and remove PPE in the proper sequence to avoid cross-contamination and/or properly wash or sanitize their hands during care for 2 of 8 residents on transmission-based isolation precautions (Residents C and G), 6 of 11 interviewed staff members who provided resident care in 5 of 5 resident units failed to be screened for fever and signs or symptoms of COVID-19 at the beginning of their shift (Registered Nurse 3; Therapist 4; Licensed Practical Nurse 5; and Certified Nurse Aides 1, 2 and 6), 13 of the 30 residents residing in the Memory Care unit were not socially distanced (positioned greater than 6 feet apart) during two observed group activities and 2 randomly observed staff members (the Medical Records Director and Certified Nurse Aide 15) failed to properly wear a medical grade face mask in 1 of 5 resident care areas (Memory Care). These deficient practices had the potential to spread infections, including COVID-19, to all 115 residents in the facility. Findings include: 1. During a tour of the facility, on 10/20/20 beginning at 9:30 a.m., the 8 residents identified by the facility as being under surveillance for COVID-19 were observed in private rooms in 3 different areas as follows: 2 residents on 2 different halls of the 20-bed 300 unit, 1 resident in the 13-bed 400 unit, 5 residents throughout the 14-bed 600 unit. Only two of the rooms were adjourning. Only one of the eight rooms had a sign(s) to indicate the resident was on isolation precautions and/or the use of specific PPE was required to enter the room. During an interview, on 10/20/20 at 9:15 a.m., the Administrator indicated there were eight residents who were on isolation precautions because, per facility protocol, recently admitted or readmitted residents were placed on isolation for 14 days and one of the residents left the facility for [MEDICAL TREATMENT]. At this time, the Administrator was requested to provide a facility floor plan color-coded with red/yellow/green zones to identify areas designated for positive COVID-19 cases (red), COVID-19 surveillance areas where residents are within 14 days of possible exposure (yellow) and areas where there were no suspected COVID-19 cases or exposure (green). During an observation and interview, on 10/20/20 at 10:43 a.m., in the 600 unit, Certified Nurse Aide (CNA) 12 was wearing a KN95 (medical grade) face mask and no eye protection. She indicated she did not know which residents were on isolation precautions for COVID-19. During an observation and interview, on 10/20/20 at 10:44 a.m., CNA 16 was wearing a KN95 face mask and no eye protection. When asked which residents in the unit were on isolation precautions for COVID-19, she identified only two of the five residents and indicated she did not know of any others on the unit. She learned who was on isolation and what type of PPE to wear by seeing the PPE in the residents' rooms. She indicated there were cloth gowns and gloves, but no face shields in the residents' rooms. She thought face shields were possibly kept at the nurses' station. During an interview, on 10/20/20 at 12:06 p.m., in the 600 unit, Licensed Practical Nurse (LPN) 13, indicated she was the unit manager. She indicated signs informing of isolation precautions were not on the five residents' doors in the 600 unit until after 11:00 a.m. on 10/20/20. When asked how the staff knew who was on isolation and what type of PPE they should wear, she indicated they knew by the equipment inside the residents' doors. She demonstrated there was a supply of face shields in a bottom drawer of the nurses' station. The facility's color-coded floor plan, provided by the Administrator on 10/20/20, reflected there was no yellow zone. The eight rooms identified by the facility as being used by residents under surveillance for COVID-19 were: one in the 400 unit, five throughout the 600 unit, and two in two different halls of the 300 unit. During an interview, on 10/20/20 at 3:00 p.m., the Administrator indicated there was no designated yellow zone. The Indiana State Department of Health Guidance for Out-of-Hospital Facilities, dated 8/17/20, reflected the following: The following is guidance for out-of-hospital facilities who house patients with a confirmed or suspected case of COVID-19. There are a few guiding principles .4. Reduce the movement of staff between patients with and without COVID-19. Cohort staff and patients in one area of the building if possible. Cohort equipment for these patients/residents to limit spread of infection 2. During an observation, on 10/20/20 at 10:48 a.m., in the 600 unit, there was no sign on recently admitted Resident C's door indicating she was on isolation precautions and what type of PPE staff should wear to enter the room. Activity Aide 11 was exiting Resident C's room wearing a KN95 face mask and carrying a cloth gown. She was not wearing eye protection. During an interview, on 10/20/20 at 10:48 a.m., Activity Aide 11 indicated she was completing Resident C's Minimum Data Set assessment tool. She indicated she did not wear a face shield or goggles while she was in Resident C's room. During an observation, on 10/20/20 at 11:58 a.m., a sign taped to the outside of Resident C's room in the 600 unit reflected she was on droplet isolation precautions. Another sign reflected: Make sure eye, nose and mouth are fully covered before entering room. CNA 12 entered Resident C's room wearing a KN95 face mask. A bedside table just inside the door had a pile of cloth gowns, gloves and one set of goggles. CNA 12 put on a gown and gloves, but no eye protection. She did not sanitize or wash her hands before putting on the gown and gloves. CNA 12 set up the resident's lunch tray leaning over the resident. She removed her PPE in the resident's restroom in the improper sequence by removing her gown and then gloves. She did not sanitize or wash her hands until after she left the room, closed the resident's door, went to the food cart down the hall, put the lunch tray lid in the cart, moved another lid and then closed the door to the cart. During an observation, on 10/20/20 at 10:01 a.m., on the 300 unit, Housekeeper 8 was standing outside recently admitted Resident G's room. There was no sign on or around the resident's door regarding isolation status or required PPE. Housekeeper 8 was wearing a KN95 face mask. The Housekeeper put on her PPE in the improper sequence by putting on a face shield first. She then put on a yellow cloth gown and disposable gloves which were stored just inside the resident's door. She did not wash or sanitize her hands before or while putting on the PPE. She entered the resident's room, picked up a disposable trash bag within six feet of the resident and disposed the trash bag into the basket attached to her cart just outside the room. With the contaminated gloves, she reached into her pocket and got the keys to the cart, opened the door to the cart and picked up a bottle of cleaning solution. She re-entered the resident's room, cleaned surfaces throughout the room and mopped the floor. She removed her PPE in the following improper sequence: gloves, then gown, then face shield. She did not sanitize or wash her hands after removing the PPE. She put on gloves, went into a near-by resident room, leaned over the resident in a chair, and removed the resident's trash. The surveyor stopped the Housekeeper before she touched the resident or other surfaces. During an interview, on 10/20/20 at 10:08 a.m., Housekeeper 8 indicated she did not sanitize her hands when she removed her PPE outside of Resident G's room and before entering the near-by resident room. During an observation, on 10/20/20 at 10:01 a.m., while Housekeeper 8 was in Resident G's room, Laundry Aide 9 was outside Resident G's room. The Laundry Aide was wearing an N95 respirator (filtered, medical grade face mask). She put on a yellow cloth gown and gloves. She was not wearing eye protection. She did not wash or sanitize her hands before putting on the gloves or entering the room. The Laundry Aide walked throughout the resident's room, within six feet of the resident as she checked both closets. When she exited the room, she removed her gloves and discarded the cloth gown into a bin in the resident's bathroom near the door. She did not sanitize or wash her hands.

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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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) During an interview, on 10/20/20 at 10:05 a.m., when asked about a face shield or goggles, Laundry Aide 9 indicated she did not know she had to wear them in Resident G's room. She did not know why Resident G was on isolation precautions. She was in the room because she was inventorying the resident's clothing. During an interview, on 10/20/20 at 3:00 p.m., the Administrator indicated there was an adequate supply of N95 face masks. He did not require N95 face masks to be worn in the rooms where residents were in isolation for COVID-19 surveillance and considered KN95 face masks to be adequate. During an interview, on 10/20/20 at 2:37 p.m., the Director of Nurses (DON) indicated staff members were expected to wear eye protection in the COVID-19 isolation rooms. There were goggles and face shields inside the isolated residents' rooms. They followed the Centers for Disease Control and Prevention (CDC) guidance related to what PPE should be worn and for the sequence of putting on and removing. Staff members were expected to wash or sanitize their hands immediately after moving PPE and before touching other surfaces. The facility's PPE Policy and Procedure, dated 2020 and provided by the DON on 10/20/20 as their policy for COVID-19 related isolation rooms, reflected the following .How to properly don, use, and doff PPE in a manner to prevent self-contamination .Respirator or Face Mask. Put on an N95 respirator (or higher level respirator) or face mask (if a respirator is not available) before entry into the patient room or care area, if not already wearing one as part of extended use or reuse strategies to optimize PPE supply .Eye Protection. Put on eye protection (i.e., goggles or a disposable face shield that covers the front and side of the face) upon entry to the patient room or care area, if not already wearing as part of extended use or reuse strategies to optimize PPE supply. Personal eyeglasses and contact lenses are NOT (emphasis as written) considered adequate eye protection. Gloves. Put on clean, non-sterile gloves upon entry into the patient room or care area .Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene Attached to the facility's PPE Policy, dated 2020 and provided by the DON on 10/20/20, were two undated flyers from the CDC which described what PPE to wear and the procedure for putting on and removing PPE. During an interview, on 10/20/20 at 3:30 p.m., the DON indicated the two fliers were the facility's current policy for putting on and removing PPE and indicated the following: - Sequence for Putting on Personal Protective Equipment .1. GOWN .2. MASK OR RESPIRATOR .3. GOGGLES OR FACE SHIELD .4. GLOVES .USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION. Keep hands away from face. Limit surfaces touched . Perform hand hygiene. - How to Safely Remove Personal Protective Equipment (PPE) Example 1 .Remove PPE in the following sequence: 1. GLOVES. Outside of gloves are contaminated! If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer .Discard gloves in a waste container. 2. GOGGLES OR FACE SHIELD. Outside of goggles or face shield are contaminated! If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer .If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container. 3. GOWN. Gown front and sleeves are contaminated! If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer .4. MASK OR RESPIRATOR. Front of mask/respirator is contaminated - DO NOT TOUCH! .5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER MOVING ALL PPE. PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE. The facility's Policy and Procedure Hand Hygiene, dated 2020 and provided by the DON on 10/20/20, reflected the following. .HCP should perform hand hygiene before and after all patient contact, contact with potentially infections material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process 3. During an observation, on 10/20/20 at 1:30 p.m., upon re-entering the facility after being off-site for an hour, the main entrance was unlocked. There was no one at the reception desk or lobby to ask whether re-entry required a second screening. Continued observation revealed the main entrance and lobby remained unsupervised for 11 minutes, until Receptionist 7 returned to her desk at 1:41 p.m. During an interview, on 10/20/20 at 3:00 p.m., the Administrator indicated a receptionist was positioned at the front lobby from 8:00 a.m. to 7:00 p.m. every day. All other entrances to the facility were locked so that all vendors, visitors, and staff could only enter through the front door. The receptionist required all persons to sanitize their hands, take their own temperature and sign the screening log to document they self-screened for the absence of COVID-19 symptoms. The receptionist was not supposed to step away from the desk. If she did, she should get someone else to take her place. At one time, they audited the sign-in/screening logs to ensure all staff members were being screened for COVID-19 symptoms but they had not done so recently. During an observation and interview, on 10/20/20 at 3:30 p.m., CNA 1 and CNA 2 were at the nurses' station of the 400 unit. They indicated they had not been screened and had not self-screened for symptoms of COVID-19, including taking their temperatures, before or during her shift. During an observation and interview, on 10/20/20 at 3:30 p.m., Registered Nurse (RN) 3 was at the nurses' station of the 300 unit. She indicated she entered the facility through the back door and did not self-screen for COVID-19 symptoms or sign the screening log at the main entrance. During an observation and interview, on 10/20/20 at 3:20 p.m., Therapist 4 was walking into the 600 unit. She indicated she entered the facility through the back door and had not been screened for COVID-19 symptoms. She did not self-screen or sign the screening log at the main entrance. During an observation and interview, on 10/20/20 at 3:35 p.m., LPN 5 was at the nurses' station of the 200 unit. She indicated she entered the building through the side door and was not screened for COVID-19 symptoms. During an observation and interview, on 10/20/20 at 3:40 p.m., CNA 6 was walking in the Memory Care unit. CNA 6 indicated she entered the facility through the entrance at the employee parking lot and was not screened for COVID-19 symptoms. During an interview, on 10/20/20 at 4:00 p.m., the DON indicated staff members were expected to come through the front door, self-screen for COVID-19 symptoms and sign the screening log. She was not aware nursing staff were entering the facility through multiple entrances. The facility's screening log, dated 10/20/20 and provided by the DON on 10/20/20 at 3:50 p.m., was reviewed and the names of CNA 1, CNA 2, CNA 6, RN 3, Therapist 4, and LPN 5 did not appear on the log to document the absence of signs or symptoms of COVID-19. 4. During an observation, on 10/20/20 at 10:33 a.m., in the Memory Care unit, 13 residents were in a small portion of the common dining room closest to the main entrance onto the unit. The 13 residents were being guided in a word game by the Memory Unit Activity Director. They were not wearing face masks and were sitting in a semi-circle next to each other in wheelchairs or dining chairs which were less than a foot apart. The attached larger side of the dining room was occupied by only four residents. During an interview, on 10/20/20 at 10:33 a.m., the 100 Unit Manager, RN 14 indicated the residents observed in the activity were not socially distanced and could spread out more into the back, larger area of the dining room during their activity. During an observation, on 10/20/20 at 1:45 p.m., 12 residents were in a small common area at the end of the Memory Care unit. The larger dining area was empty except for two staff members. All 12 residents were not wearing face masks and were sitting side-by-side in a circle with less than a foot between them: five in wheelchairs, and seven in chairs. The Memory Unit Activity Director was wearing a KN95 face mask and was leading them in group singing. During an observation and interview, on 10/20/20 at 2:00 p.m., the DON observed the singing activity in the Memory Care unit just as it was concluding. She indicated the residents should have been spaced out more. They could have used the dining room after it was cleaned or done the activity in two sessions so there were not so many residents clustered together. The CDC's guidance: Considerations for Memory Care Units in Long-term Care Facilities dated 05/12/20 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html, reviewed on 10/21/20) reflected the following: .nursing homes and assisted living facilities providing memory care should consider the following: .Continue to provide structured activities, which may need to occur in the resident's room or be scheduled at staggered times throughout the day to maintain social distancing .Limit the number of residents or space residents at least six feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel 5. During an observation, on 10/20/20 at 10:33 a.m., in the Memory Care unit, the Medical Records Director was sitting at the nurses' station with two other staff members. She was wearing a cloth face mask. During an observation on, 10/20/20 at 10:35 a.m., in the same Memory Care unit, CNA 15 was walking out of a resident's room. She was wearing a KN95 face mask under her nose and carrying a trash bag. She took the trash bag into the trash/laundry room and came out with the KN95 face mask still under her nose. An unidentified CNA walked in and out of the trash/laundry room with CNA 15 and did not direct CNA 15 to lift her face mask to above her nose. CNA 15 did not raise her face mask above her nose until this surveyor asked her about it. During these continued observations, two male residents were walking in the hallway. One of the two residents stopped and chatted with the nurses at the same nurses' station. Seventeen residents were in the nearby common dining room. During an interview, on 10/20/20 at 10:33 a.m., the Medical Records Director indicated she was in the unit entering Face Sheets. She indicated she did not have another mask under her cloth mask. During an interview, on 10/20/20 at 2:37 p.m., the DON indicated cloth masks could not be worn in a resident area. All masks must be worn above the mouth and nose. The Indiana State Department of Health Epidemiology Resource Center guidance: COVID-19 Information for Long-Term Care Facilities, last updated on 08/17/20

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