STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING _____ B. WING _____	**10/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COMMUNITY NURSING AND REHABILITATION CENTER	**5600 E 16TH ST INDIANAPOLIS, IN 46218**

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 to help prevent the development and transmission of communicable diseases and infections by staff members not wearing face masks correctly, isolation trash cans in hallways outside of isolation rooms, two nursing staff members wearing contaminated PPE (Personal Protection Equipment) in hallway during a random observation, isolation room doors open to the hallway for 5 rooms on the 100 hallway and 2 rooms on the 200 hallway, and placing residents, who were on isolation, in a room with a non-isolation resident for 4 of 5 resident reviewed for COVID monitoring (Residents 8, 18, 52, and 61). Findings include: 1. a. An observation was made on 10/15/20 at 11:30 a.m., of LPN 1 (Licensed Practical Nurse) sitting at the 1st floor nursing station with her mask pulled down below her nose and mouth leaving her nose and mouth uncovered. Another staff member was in the nursing station at that time. b. An observation was made on 10/15/20 at 11:33 a.m., of HK 2 (Housekeeping) exiting a resident room with her mask pulled down leaving her nose uncovered. c. An observation was made on 10/15/20 at 11: 44 a.m., of CNA 3 (Certified Nursing Assistant) exiting the stairwell with a fell ow staff member. CNA 3 had her mask pulled down below her nose and mouth leaving them uncovered. CNA 3 and the other staff member were walking side by side and not 6 feet apart. An interview with IP (Infection Preventionist) was conducted on 10/15/20 at 2:58 p.m. IP indicated the staff has been in-serviced on the proper way to wear a mask, as well as, the need to wear a mask at all times when in the facility. 2. An observation was made of the 1st floor hallway on 10/15/20 at 11:29 a.m. a. In the hallway, outside of Resident 8 and 18's room, was an isolation trash can containing used PPE. b. In the hallway, outside of Resident 22's room, was an isolation trash can containing used PPE. c. In the hallway, outside of Resident 10's room, was an isolation trash can containing used PPE. An interview with DON (Director of Nursing) conducted on 10/15/20 at 12:02 p.m., indicated, the trash cans should not be housed in the hallway but should have been inside the residents' rooms. CDC Infection Control Guidance for Nursing Homes and Long Term Care Facilities indicated, Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room. 3. a. An observation was made on 10/15/20 at 11:40 a.m., of LPN 2. LPN 2 had exited a Droplet + isolation room with used PPE on and then removed the PPE in the 100 hallway. b. An observation was made on 10/15/20 at 11:43 a.m., of LPN 3. LPN 3 had exited a Droplet + isolation room with used PPE on and then removed the PPE in the 100 hallway. c. An interview with DON conducted on 10/15/20 @ 12:02 p.m., indicated prior to exiting a transmission based precaution room, staff should remove PPE prior to exiting the room. 4. An observation was made of the 1st floor hallway on 10/15/20 at 11:29 a.m. The following Droplet + isolation precaution rooms had their doors left open to the hallway: 128, 132, 135, 136, and 140. The Droplet + isolation resident rooms have non isolation rooms in between them. The following rooms are next to or beside isolation rooms on the 100 hallway and have non isolation residents residing in them: 123, 125, 126, 131, 133, and 134. An observation was made of the 2nd floor hallway on 10/15/20 at 12:18 p.m. room [ROOM NUMBER] was on Droplet + isolation precautions and had the room door open to the hallway. room [ROOM NUMBER] and room [ROOM NUMBER] are Droplet + isolation rooms on the 200 hallway. All other residents on the 200 hallway are not in any isolation precautions. room [ROOM NUMBER] is more toward the middle of the hallway and room [ROOM NUMBER] is at an end of the hallway. A COVID-19 Resident Policy was provided by the DON on 10/15/20. The policy indicated, f. The doors of newly admitted residents will remain closed unless resident's safety dictates otherwise (i.e. fall risk, bedbound who are in critical need of observation need to open door for anxiety or behavioral reasons). Privacy curtains will remain closed and cohorted residents will have their beds at least 6 feet apart. They will have a dedicated bathroom, bedside commode, or bedpan .Residents Suspected or Confirmed with COVID-19 .6. The resident will be placed on Droplet Plus Precautions and signs will be placed outside of the patient's room The door should remain shut unless the resident's safety dictates otherwise (i.e. fall risk, bedbound who are in critical need of observation need to open door for anxiety or behavioral reasons), or they resident on an all COVID unit that is contained by doors or by temporary solid barrier . 5. a. The clinical record for Resident 61 was reviewed on 10/15/20. Resident 61's [DIAGNOSES REDACTED]. Resident 61 was readmitted to the facility following a hospitalization on [DATE]. Resident 61 was readmitted into a room with Resident 52 and placed on Droplet + precautions. Per the facilities policy for readmission of a resident, Resident 61 was placed on Droplet + precautions. Resident 52 had not been recently admitted /readmitted nor was on any transmission based precautions prior to Resident 61 becoming his roommate. This placed Resident 52 at risk for COVID-19. b. The clinical record for Resident 18 was reviewed on 10/15/20. Resident 18's [DIAGNOSES REDACTED]. Resident 18 was readmitted to the facility following a hospitalization on [DATE]. Resident 18 was readmitted into a room with Resident 8 and placed on Droplet + precautions. Per the facilities policy for readmission of a resident, Resident 18 was placed on Droplet + precautions. Resident 8 had not been recently admitted /readmitted nor was on any transmission based precautions prior to Resident 18 becoming his roommate. This placed Resident 8 at risk for COVID-19. An interview with DON was conducted on 10/15/20 at 2:16 p.m. DON indicated, residents returning from the hospital are placed on Droplet + precautions for 14 days no matter if they had a COVID test prior to discharge from the hospital. DON stated the readmissions should have been placed in private rooms. A COVID-19 Resident Policy was provided by the DON on 10/15/20. The policy indicated, admissions and readmissions with unknown COVID-19 status should be placed in a designated area and all residents with unknown COVID-19 status will be placed in 14-day observation for COVID-19 on Droplet + precautions. The facility should always default to the 14-day quarantine in the observation area with transmission-based precautions in place unless special circumstances are present. 3.1-18(b)

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.