STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING _____ B. WING _____	04/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

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 -** Immediate jeopardy **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure infection control practices for COVID-19 were followed to ensure residents free from symptoms of the COVID-19 infection, on the dementia care unit, were not exposed to and roomed with residents who were positive for the COVID-19 infection for 2 of 22 residents on the dementia unit (Residents B and K). This deficiency had the potential to affect 15 of 22 residents on the dementia care unit. The immediate jeopardy began on 4/11/20, when the facility elected to make the dementia care unit the COVID-19 isolation unit. The day prior, 4/10/20, two residents who already resided on the dementia care unit had been determined to be positive for the COVID-19 infection (Residents F and G). On 4/11/20, Residents C, D and E were moved from the 300 hall (the facility's initial isolation unit) into the dementia care unit. The other residents, who resided on the dementia care unit, were not transferred out of the unit when the COVID-19 positive residents were moved onto the unit. Two of the positive COVID-19 residents (Residents C and H) were placed into rooms with two residents (Residents B and K) who were not symptomatic of COVID-19. This placed the two dementia care residents, as well as the other residents on the dementia care unit, at risk of developing the COVID-19 infection. The Executive Director (ED) and the Director of Nursing (DON) were notified of the immediate jeopardy on 4/16/20 at 1:43 p.m. The immediate jeopardy was removed on 4/19/20, but noncompliance remained at pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During an interview, on 4/16/20 at 9:58 a.m., the Executive Director (ED) indicated there were seven positive COVID-19 infection cases in the facility. They had established the dementia care unit the isolation unit. On 4/10/20, two of the residents who resided on the dementia unit had tested positive for the COVID-19 infection. Both of the residents wandered around the unit regularly. The ED indicated, since the residents had been in close contact with the other residents on the unit, prior to being determined as positive with the infection, the remainder of the residents on the unit were considered presumptive positive for the infection. It was at this time, the facility elected to make the dementia care unit the isolation unit for COVID-19 infections. Prior to that time, they had been using a small portion of the 300 hall as the isolation unit, since it had fire doors that could close it off from the remainder of the facility. On 4/11/20, the other COVID-19 positive residents were transferred to the dementia care unit. Due to lack of available beds, they had to place a positive female (Resident C) into a room with a female dementia resident (Resident B) who was asymptomatic and had not been tested , and a positive male resident (Resident H) into a room with a male dementia resident (Resident K) who was asymptomatic and had not been tested . No communal activities or communal dining were being held on the unit. The staff would redirect any wandering residents in an attempt to maintain social distancing. During an interview, on 4/16/20 at 11:15 a.m., the ED indicated there were 22 residents who resided on the dementia care unit, including the seven residents who were positive for COVID-19. The facility did not have a plan to test any resident unless they exhibited sign/symptoms, or unless requested by physician or family. During an observation, on 4/16/20 at 11:52 a.m., the 200 hall was observed to be the locked dementia and isolation unit. On 4/16/20 at 12:20 p.m., the ED provided a document, titled Number of Residents Presenting with Infectious Symptoms, and indicated it contained the current facility information for residents with active COVID-19 infection. The document indicated the dates of the COVID-19 testing and dates when the residents had been determined to be COVID-19 positive. The information on the document included, but was not limited to: -Resident D: The resident had been tested on [DATE], due to cough. Positive results had been received on 4/7/20. The resident had been initially placed on the 300 hall and had been transferred to the dementia unit on 4/11/20. The resident had been placed into a room with another COVID-19 positive resident (Resident E). -Resident E: The resident had been tested on [DATE], due to change in Activities of Daily Living (ADL) status. Positive results had been received on 4/9/20. The resident had been initially placed on the 300 hall and had been transferred to the dementia unit on 4/11/20. The resident had been placed into a room with another COVID-19 positive resident (Resident D). -Resident F: The resident had been tested on [DATE], due to complaint of sore throat. Positive results had been received on 4/10/20. The resident already resided on the dementia care unit, with a COVID-19 positive resident (Resident G). -Resident G: The resident had been tested on [DATE], due to her roommate's complaint of sore throat and the roommate being tested . Positive results had been received on 4/10/20. The resident already resided on the dementia care unit, with a COVID-19 positive resident (Resident F). -Resident C: The resident had been tested on [DATE], due to a family request. Positive results had been received on 4/11/20. The resident had been initially placed on the 300 hall and had been transferred to the dementia unit on 4/11/20. The resident had been placed into a room on the dementia unit with Resident B, who was asymptomatic. -Resident H: The resident had been tested on [DATE], due to cough and change in ADL status. Positive results had been received on 4/14/20. The resident was moved from his room on the 100 hall to the dementia unit on 4/14/20. The resident had been placed into a room on the dementia unit with Resident K, who was asymptomatic. -Resident J: This resident's name did not appear on the document. According to the ED, the resident had transferred from a sister facility. The resident had been determined positive for the COVID-19 infection prior to being transferred. The resident required [MEDICAL TREATMENT], and the [MEDICAL TREATMENT] unit he had used prior to the transfer had refused to serve him due to his COVID-19 positive status. He was approved for [MEDICAL TREATMENT] in the area of the facility and had been transferred and had been placed on the dementia unit in a room by himself. During an observation of the 200 hall dementia unit on 4/17/20 from 4:20 p.m. to 4:50 p.m., Resident B's and Resident C's names were observed on a room with a droplet isolation sign on the door. Resident K's and Resident H's names were also observed on a room with a droplet isolation sign on the door. During an observation of the 200 hall dementia unit and interview on 4/17/20 at 4:35 p.m., the Nurse Consultant came out of a room with a droplet isolation sign on the door wearing a gown and mask. She indicated she had taken her gloves off and washed her hands before exiting the room. She had not removed her gown because they were wearing the same gown to all positive rooms then changing into a new gown and mask before entering a negative person's room. She indicated staff was changing gowns for non positive resident rooms to preserve gowns. However, she was leaving the unit, so she would be doffing her PPE. Nurse Consultant was observed to go into a staff-only room next to the nurse's station and doff gown and wash hands. The CDC (Center for Disease Control) guidance for Use of PPE (personal protective equipment) when caring for Patients with a Confirmed or Suspected COVID-19 was reviewed. The removal of PPE guidance included, but was not limited to: 1. Remove gloves. 2. Remove gown. 3. Healthcare provider may now exit room. 4. Perform hand hygiene. 5. Remove face shield or goggles. 6. Remove respirator. 7. Perform hand hygiene. 1. On 4/17/20 at 5:10 p.m. Resident B's record was reviewed. A form titled, Admission Record, printed 4/17/20, indicated Resident B had [DIAGNOSES REDACTED]. A physician order, dated 3/19/20, indicated check vital signs every shift for 90 days. A form titled, Weights and Vitals Summary, dated 3/25/20 to 4/17/20, indicated Resident B had temperatures below 99 degree Fahrenheit (F) except for 2 days. On 3/30/20 Resident B had a temporal artery temperature of 99 degrees F and on 4/16/20 she had a temporal artery temperature of 99.5 F. A physician order, dated 4/17/20, indicated

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Contact/Droplet isolation for positive COVID- 19. A physician order, dated 4/17/20, indicated check vital signs every 4 hours for 90 days. 2. On 4/17/20 at 5:15 p.m. Resident K's record was reviewed. A form titled, Admission Record, printed 4/17/20, indicated Resident K had [DIAGNOSES REDACTED]. A physician order, dated 3/19/20, indicated check vital signs every shift for 90 days. A physician order, dated 4/17/20, indicated check vital signs every 4 hours for 90 days. A physician order, dated 4/17/20, indicated Contact/Droplet isolation for exposure to COVID- 19. A form titled, Weights and Vitals Summary, dated 3/26/20 to 4/17/20, indicated Resident K had temperatures below 99 degree Fahrenheit (F) except for one day. On 4/9/20 Resident K had a temporal artery temperature of 99.1 degrees F. During an interview on 4/19/20 at 12:54 p.m., the ED indicated the remainder of the residents on the dementia unit had been tested for COVID-19 on 4/17/20, and the results of COVID-19 testing had indicated Resident B was positive for COVID-19. They had not received all of the results for the residents yet. Resident K's results were inconclusive, and the facility was going to swab them today to get results. During a telephone interview on 4/19/20 at 3:40 p.m., the ED indicated he had received a call with results for the three residents who had been inconclusive, and they were positive. The ED indicated all of the residents on the locked dementia unit were now positive for COVID-19 except for two residents. The Indiana State Department of Health (ISDH) Guidance for out-of-hospital facilities, dated 3/29/20, indicated, 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: .Patients/residents with known or suspected COVID-19 should be cared for in a single-person (private) room with the door closed .Patients/residents with known or suspected COVID-19 should not share bathrooms with other patients/residents. All patients/residents returning from the hospital with suspected or confirmed COVID-19 should be cared for in a private room, or cohorted with other patients of the same status in the same unit, wing, hallway, or building CDC guidance, accessed at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, on 4/17/2020, entitled, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, included the following: Dedicate space in the facility to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Assign dedicated HCP to work only in this area of the facility. Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive). Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them. Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their exposure (or admission). Testing at the end of this period could be considered to increase certainty that the resident is not infected. If an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved from their rooms to this location while undergoing evaluation. All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. CDC guidance, accessed at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, on 4/17/2020, entitled, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, included the following: It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens might be housed on the same unit. However, only patients with the same respiratory pathogen may be housed in the same room. For example, a patient with COVID-19 should ideally not be housed in the same room as a patient with an undiagnosed respiratory infection. The immediate jeopardy that began on 4/11/20 was removed on 4/19/20 when the facility had inserviced staff, tested all residents on the dementia unit and cohorted and/or isolated residents appropriately. Noncompliance remained at the reduced scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because of the facility's need to continue to monitor. This Federal tag related to Complaints IN 612 and IN 657. 3.1-18(a)