STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155145	A. BUILDING _____ B. WING _____	04/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WASHINGTON NURSING CENTER	603 E NATIONAL HWY WASHINGTON, IN 47501

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 0624 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe and orderly transfer of residents. Residents were loaded onto buses for relocations to different facilities that were started but never finished. One bus left in the morning, returned, left again, and returned again over a period of several hours. During this time, the 6 residents on the bus were not permitted to return to the facility. A second bus with 6 residents left in the early afternoon, only to turn around and return to the facility before reaching its destination. Before and during these events, the facility failed to sufficiently explain to residents or staff why they were leaving the facility and being relocated, failed to adequately notify or work with resident families or other resident representatives regarding the relocations, failed to ensure staff members minimized resident anxiety and fear (actually increasing both instead), subjected residents to unsafe, confined conditions and failed to ensure residents on the buses received scheduled medication doses and necessary incontinence care. These failures caused residents physical and psychosocial distress over extended periods of time (Residents B, C, D, F, G, H, K, Q, R, S, T, U). Three additional residents who were not on the buses were also distressed (Residents N, P, and V). This deficient practice affected 15 of 50 residents residing at the facility, all of whom were planned for transfer on 4/06/20. The Immediate Jeopardy began on the morning of 4/06/20 when residents were first loaded onto buses. The Administrator, Director of Nursing (DON), Corporate Nurse, and Regional Director of Operations (RDO) were notified of the Immediate Jeopardy on 4/09/20 at 3:00 P.M. The Immediate Jeopardy was removed on 4/09/20, but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: 1. On 4/06/20 at 4:50 P.M., the Administrator was interviewed. She indicated she was informed by the facility's corporate staff on Friday, 4/03/20, that all residents were to be transferred to one of two different sister facilities on Monday, 4/06/20. One facility was two hours away, and one facility was 1/2 hour away. The residents were to be transferred so that facility operators could prepare the building to be a dedicated COVID-19 facility. No residents of the facility had tested positive or shown symptoms of COVID-19. The Administrator said she understood that an emergency waiver had been obtained to permit the immediate transfer of the residents. She indicated she was unsure what time the first bus left on 4/06/20, but knew the residents had returned to the facility on ly to be driven off again, she thought back to the other facility. She thought the residents were gone for approximately 1 1/2 hours. She indicated the residents were offered sandwiches and drinks after the first return trip, while the bus sat in the facility's parking lot. Some residents ate on the bus, and some ate outside. She indicated the residents were able to leave the bus to eat if they wanted to. She was unsure when the residents were finally unloaded from the bus. She said another bus was loaded with residents at the time, but had not yet left the facility. She was unsure how long those residents remained on the second bus. On 4/06/20 at 5:35 P.M., the Administrator provided a document which included the following: List of residents going to (Facility B). Bus left 1st time at approximately 9:30 (Residents Q, G, D, H, B, R). Bus returned at approximately 12:00 pm 2nd bus going to (Facility B) @ approximately 1:15 (sic): (Residents C, F, S, T, U, and K). On 4/06/20 at 6:05 P.M., the Activity Director (AD) was interviewed. She indicated she had driven the first bus that day. She indicated the residents on the first bus required assistance to enter and some utilized wheelchairs. She was unsure of the time they loaded the bus, but thought it was around 9:30 A.M. The AD drove the first bus with six residents toward one of the sister facilities. When the bus had traveled for about 1 1/2 hours, she received a phone call with instructions to return to the facility, so she turned around. She thought they returned to the facility at approximately 12:00 P.M. The RDO told the AD to keep the residents on the bus, and the bus sat in the facility parking lot. Some residents on the bus were allowed to go to the bathroom but made to return to the bus. The residents ate on the bus. The AD indicated at approximately 1:15 P.M., she was told to leave again with the residents. After approximately 10-15 minutes, the AD received a second phone call, again instructing her to return to the facility. The first bus returned and the residents were unloaded and returned to the facility. She thought a second bus loaded with six residents left at around the same time the first bus returned, but that it also had to turn around and return. The AD thought the residents were unloaded from both buses at approximately 2:15 P.M. - 2:30 P.M. Confidential interviews were conducted during the course of the survey. On 4/06/20, during a confidential interview, the interviewed person said residents were on the first bus all day. The residents ate lunch on the bus. The person said, It was awful. On 4/06/20, during a second confidential interview, the interviewed person indicated the first group of six residents got on the first bus at approximately 8:00 A.M. Six more residents got on a different bus 30 or 40 minutes later. After the first bus returned the first time, the residents on board were not allowed to get off the bus. While the first bus was parked at the facility with the residents on board, CNA 1 took two residents off who had to go to the bathroom. They had to eat lunch on the bus. It was pretty bad. Residents were sweating. The Administrator told staff they had to help load residents on the bus or they would be terminated. On 4/06/20, during a third confidential interview, the interviewed person indicated staff started loading residents on the first bus at approximately 8:00 A.M. Staff were given no direction other than to load the residents, had no clue what was going on, and were rushing the residents to get loaded. The person indicated, Residents were crying; residents were scared. The first bus was loaded around 8:30 A.M., and the residents were not allowed off until about 2:30 P.M. The first bus left, then came back, then left and came back again. Staff members were screaming, Do not take them off that bus. Residents on the bus were hyperventilating. One resident's oxygen tank was low. Staff members were told they could be terminated if they didn't help. Resident G was crying hysterically. Resident P was not on the bus, but was really upset. Resident F and Resident H had diarrhea in their briefs, and staff weren't allowed to change them. On 4/06/20, during a fourth confidential interview, the interviewed person indicated 12 residents were loaded onto two buses at approximately 9:00 A.M. When they came back, they were told to leave them on the buses. One resident had to go to the bathroom, so staff took him off so he could use the bathroom and then returned him to his bus. The residents ate lunch on the bus and were given water. The interviewed person was unsure what time the residents were unloaded from the bus. One resident was crying; I know I wasn't supposed to, but I just hugged her. On 4/07/20, during a fifth confidential interview, the interviewed person indicated residents loaded onto the morning bus were given medications at 8:00 A.M. Staff were told to put residents' medications for their mid-day doses into a bag, which was kept on the bus with the residents. Although the medications were on the bus, the DON did not allow them removed from the bags. No medications were administered to residents on the bus at noon or 1:00 P.M. on 4/06/20. On 4/07/20, during a sixth confidential interview, the interviewed person said she heard the RDO say, Do not take them (the residents) off the bus. This was at lunchtime on 4/06/20. She was unsure how long the residents were on the bus. On 4/07/20 at 10:50 A.M., a local law enforcement officer was interviewed. The officer indicated it was his analysis residents had endured 3 - 4 hours on the bus, during the departures and returns. On 4/07/20 at 4:20 P.M., the RDO, the Administrator, the DON, and a DON from a sister facility were interviewed. The RDO indicated the residents on the first bus were on the way to a sister facility. When that bus was approximately 1 1/2 hours away, the facility received an abatement order from the local health department, so the bus driver was phoned and instructed to return to the facility. The RDO indicated he understood the

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

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A physician's orders [REDACTED].M. and 5:00 P.M. A Medication Administration Record [REDACTED].M., and the resident did not receive his insulin at 12:00 P.M. The resident's accucheck at 4:00 P.M. was 200, which was the highest reported accucheck at 4:00 P.M. since April 1, 2020. During an interview with RN 2, on 4/07/20 at 9:25 A.M., she indicated she was Resident C's nurse on 4/06/20. She said she was not able to administer Resident C's insulin at 12:00 P.M. 3. On 4/06/20 at 5:25 P.M., Resident D was interviewed. Resident D indicated, I was on the first bus. We left early in the morning, at around 9:00 A.M., turned around and came back, and left again. Resident D indicated he got off the bus at approximately 2:30 P.M. He indicated residents ate lunch on the bus. The clinical record of Resident D was reviewed on 4/07/20 at 10:10 A.M. [DIAGNOSES REDACTED]. A quarterly MDS assessment, dated 1/24/20, indicated the resident had no memory impairment, and required set up supervision with transfers and ambulation. A physician's orders [REDACTED]. The April 2020 MAR indicated [REDACTED].M. on 4/06/20. The reason documented was absent from home. During an interview with RN 2, on 4/07/20 at 9:25 A.M., she indicated she was unable to administer Resident D's 1:00 P.M. medications on 4/06/20. 4. On 4/06/20 at 5:30 P.M., Resident F was interviewed. Resident F indicated she got on the first bus, and they got a phone call and had to turn around and come back. She indicated they left and came back 3 or 4 times. She indicated she was told she had to go to (another facility two hours away). She had to sit on there in the hot heat. But they brought us ice water. Resident F asked if she was still going to be transferred. The clinical record of Resident F was reviewed on 4/07/20 at 2:44 P.M. [DIAGNOSES REDACTED]. A quarterly MDS assessment, dated 2/18/20, indicated Resident F had no memory impairment, and required total assistance of two or more staff for transfers. On 4/07/20, during a confidential interview, the interviewed person indicated Resident F was upset while on the bus. 5. On 4/06/20 at 7:10 P.M., Resident B was interviewed. Resident B was lying in bed, and had her oxygen on at 2 liters per minute. Resident B indicated she got on a bus that morning at approximately 9:30 A.M., because she was told she was going to (another facility two hours away). Resident B indicated, I never got off the bus. I didn't want to get on and off. It was a nightmare. She added the bus ride seemed like an 8 hour trip. She used her portable oxygen on the bus. She stated, It could have been bad if I had run out. She was unsure of the time that she finally got off of the bus, but indicated it was after lunch. On 4/07/20 at 2:35 P.M., the clinical record of Resident B was reviewed. [DIAGNOSES REDACTED]. A significant change MDS assessment, dated 3/04/20, indicated Resident B was moderately impaired in cognition, and required extensive assistance of one staff for transfers. A physician's orders [REDACTED].@ 2 LPM (liters per minute) - may remove for transport. 6. On 4/06/20 at 5:35 P.M., the Administrator provided a list of residents, highlighting those considered interviewable. Resident N was highlighted as interviewable. On 4/06/20 at 5:30 P.M., Resident N was interviewed. Resident N indicated she did not get on a bus, but watched as residents got on and off the bus. Resident N indicated the residents were on the bus for 3 or 4 hours. Resident N indicated she was told she had to go to another facility also, but that she just wanted to go home. 7. On 4/06/20 at 5:35 P.M., the Administrator provided a list of residents who were considered interviewable. Resident V was considered interviewable. On 4/08/20 at 2:20 P.M., Resident V requested an interview. She indicated she was very upset. She thought they were going somewhere on Monday, 4/06/20. She did not get on a bus, but was getting ready to get on a bus. She had lived at the facility for nine years, and didn't want to leave. She stated, It made me sad and shocked. Resident V indicated she was informed of the transfer either on Saturday or Sunday, before the anticipated Monday move. Resident V went along with it. Then the buses left, turned around and came back, then left and came back. Resident V didn't understand what was going on. She indicated, It was a total disaster for us. No one cared for the residents. She indicated the facility gave her two choices, either facility A or facility B. 8. On 4/06/20, during a confidential interview with a family member, the family member indicated they were not informed by any means of communication prior to reading something on social media on Saturday, 4/04/20, that their family member was to be transferred to another facility. They weren't given a choice on where to send their resident. 9. On 4/06/20, during a confidential interview with a family member, the family member indicated the family was not informed by phone or letter that their relative was to be transferred to another facility. They were not given a choice on where to send the resident. The family member indicated they were upset, and the resident was upset. 10. On 4/07/20 at 3:00 P.M., the Administrator indicated there was no written plan regarding the residents' transfers. All residents had on wrist bands, and a list was made regarding what facility each resident was going to. There were to be two CNAs on each bus. On 4/08/20 at 3:30 P.M., the Administrator provided the current facility policy, Transfer or Discharge, Preparing a Resident for, dated December 2016. The policy included: Residents will be prepared in advance for discharge .the business office will notify nursing services of the transfer or discharge so that appropriate procedures can be implemented. The Immediate Jeopardy that began on 4/06/20 was removed on 4/09/20 when the facility continued staff education/inservices regarding resident rights, transportation, medication administration, and transfers, but noncompliance remained at the lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because monitoring and inservicing would be ongoing. This Federal tag relates to Complaints IN 915 and IN 986. 3.1-12(a)(21)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and their representatives were invited to participate in care planning conferences for 3 of 3 residents reviewed. (Resident K, Resident V, Resident Z) Findings include: 1. On 4/9/20 at 2:11 P.M., Resident K indicated he had not been invited to participate in his care planning conferences. On 4/9/20 at 2:25 P.M., Resident K's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 2/5/20, indicated Resident K had moderate cognitive impairment and [DIAGNOSES REDACTED]. The Sign-In/Attendance Record for Care Plan Meeting form, indicated Resident K's last care planning conference was 11/26/19. The form did not indicate if Resident K or his representative was invited to attend or attended the care planning conference. On 4/9/20 at 2:55 P.M., the Social Service Director indicated she could not find any additional documentation related to Resident K's care planning conferences. 2. On 4/9/20 at 2:12 P.M., Resident V indicated her husband had been invited to participate in her care planning conferences. On 4/9/20 at 2:30 P.M., Resident V's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 1/29/20, indicated Resident V had no cognitive impairment and [DIAGNOSES REDACTED]. The Sign-In/Attendance Record for Care Plan Meeting form, indicated Resident V's last care planning conference was 11/26/19. The form did not indicate if Resident V or her representative was invited to attend or attended the care planning conference. On 4/9/20 at 2:55 P.M., the Social Service director indicated she could not find any additional documentation related to Resident V's care planning conferences. 3. On 4/9/20 at 2:10 P.M., the closed clinical record of Resident Z was reviewed. The resident was admitted to the facility on [DATE]. A Sign-In/Attendance Record for Care Plan Meeting, dated 10/22/19, was signed by the resident and 5 staff members. Additional care plan meeting notes, dated 11/19/19 and 11/26/19, were signed by staff members, but not the resident. Documentation that the resident and/or family was invited to the care plan meetings was not found in the clinical record. Further documentation of care plan meetings was not found in the clinical record. On 4/9/20 at 4:00 P.M., the Administrator indicated she could not find additional information regarding the care plan meetings. She indicated the facility did not have a Social Services Director for a short time. The current SSD had been at the facility for approximately 5 weeks. On 4/9/20 at 4:10 P.M., the Administrator provided the current facility policy, Care Planning, undated. The policy included, Resident, family, or legal representative must be invited to each care plan conference. If they attend, their presence will be documented by their original signatures on the care plan form. Their inability to attend will be documented in the social service progress notes or care plan conference summary At that time, the Administrator provided an additional current facility policy, Care Planning Conference, undated. The policy included: A

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) patient care planning team coordinator is assigned to conduct the meeting. This person is responsible to (sic) keeping attendance and taking minutes of the meeting if applicable. Attendance forms are kept in a binder or notebook This Federal tag relates to Complaint IN 811. 3.1-35(d)(2)(B)
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a care plan regarding discharge, for 1 of 3 residents reviewed for discharge plans (Resident Z). Findings include: On 4/9/20 at 2:10 P.M., the closed clinical record of Resident Z was reviewed. The resident was admitted to the facility on [DATE]. A Sign-In/Attendance Record for Care Plan Meeting, dated 10/22/19, included: Therapy: D/C (discharge) plans ???. Additional care plan meeting notes, dated 11/19/19 and 11/26/19, were signed by staff members, but not the resident. Documentation that the resident's discharge was discussed was not found in the clinical record. Further documentation of care plan meetings was not found in the clinical record. Care Plans did not include a plan for the resident's discharge. On 4/9/20 at 4:00 P.M., the Administrator indicated she could not find additional information regarding the care plan meetings or discharge. She indicated the facility did not have a Social Services Director for a short time. The current SSD had been at the facility for approximately 5 weeks. On 4/9/20 at 4:10 P.M., the Administrator provided the current facility policy, Care Planning, undated. The policy included, All Residents will have a plan of care .This plan of care will be a permanent part of the Resident's clinical medical record .Discharge potential and plan should be indicated and reviewed at every care conference. This Federal tag relates to Complaint IN 811. 3.1-12(a)(18)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were provided care and services to meet their needs, related to medications were not administered and accuchecks (blood sugar monitoring) were not completed or obtained as care planned and ordered by the physician, for 2 of 5 residents reviewed for quality of care. (Residents C and D) Findings include: 1. On 4/6/20 at 5:20 P.M., Resident C was interviewed. Resident C indicated he had been on a bus for an extended period on 4/6/20. The clinical record of Resident C was reviewed on 4/7/20 at 2:40 P.M. [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment, dated 3/13/20, indicated the resident had no cognitive impairment. The resident had an active [DIAGNOSES REDACTED]. The Interventions included: Accuchecks (blood sugar checks) as ordered. Administer diabetes medications/insulin as ordered, monitor for effectiveness and adverse reactions. A physician's orders [REDACTED]. A physician's orders [REDACTED].M. and 5:00 P.M. A Medication Administration Record [REDACTED].M., and the resident did not receive his insulin at 12:00 P.M. The resident's accucheck at 4:00 P.M. was 200, which was the highest reported accucheck at 4:00 P.M. since April 1, 2020. During an interview with RN 2, at 4/7/20 at 9:25 A.M., she indicated she was Resident C's nurse on 4/6/20. She said she was not able to administer Resident C's insulin at 12:00 P.M. on 4/6/20. 2. On 4/6/20 at 5:25 P.M., Resident D was interviewed. Resident D indicated he had been on a bus for an extended period of time on 4/6/20. The clinical record of Resident D was reviewed on 4/7/20 at 10:10 A.M. [DIAGNOSES REDACTED]. A quarterly MDS assessment, dated 1/24/20, indicated the resident had no memory impairment, and required set up supervision with transfer and ambulation. Active [DIAGNOSES REDACTED]. A Care Plan, initially dated 7/20/19 and updated 1/16/20, indicated, The resident uses [MEDICAL CONDITION] medications r/t (related to) anxiety, depression, psychological disorder ([MEDICAL CONDITIONS], mood (disorder). The Interventions included: Administer meds (medications) as ordered, monitor for effectiveness and adverse reactions. A Care Plan, dated 2/6/20, indicated, Risk for [MEDICAL CONDITION] Activity: Dx (diagnosis) of [MEDICAL CONDITION]. The Interventions did not include administering medications as ordered. A physician's orders [REDACTED]. The April 2020 MAR indicated [REDACTED].M. on 4/6/20. The reason documented was absent from home. During an interview with RN 2, on 4/7/20 at 9:25 A.M., she indicated she was unable to administer Resident D's medications at 1:00 P.M. on 4/6/20. On 4/7/20, during a confidential interview, the interviewed person indicated residents loaded onto the morning bus on 4/6/20 were given medications at 8:00 A.M. Staff were told to put residents' medications for their mid-day doses into a bag, which was kept on the bus with the residents. Although the medications were on the bus, the DON did not allow them removed from the bags. No medications were administered on the bus at noon or 1:00 P.M. on 4/6/20. This Federal tag relates to Complaints IN 915 and IN 986. 3.1-37(a)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **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 the standardized infection control procedures to protect residents from a potential COVID-19 outbreak for 4 of 4 residents reviewed. Surgical masks were not worn properly, isolation precautions were not implemented, isolation carts were not available, alcohol based hand rub was not available in resident rooms, and the screening thermometer was not sanitized between uses. (Resident J, Resident X, Resident Y, Resident W) Findings include: 1. On 4/7/20 at 10:12 A.M., Resident J was observed sleeping in bed. The door to the room was observed to be open. There was no isolation cart or sign posted on the resident's door. On 4/7/20 at 10:30 A.M., Resident J's clinical record was reviewed. The Quarterly MDS (Minimum Data Set) assessment, dated 3/4/20, indicated Resident J had minimum cognitive impairment and required set up assistance and supervision for bed mobility, transfers, dressing, bathing, and toileting. A physician's orders [REDACTED]. The physician's orders [REDACTED].M., 100 degrees Fahrenheit 4/4/20 at 5:38 A.M., 100.6 degrees Fahrenheit 4/4/20 at 5:28 P.M., 99 degrees Fahrenheit 4/5/20 at 11:17 A.M., 99.1 degrees Fahrenheit The Progress Notes included, but were not limited to: 4/3/20 at 1:55 P.M., Temperature of 100, sore throat two days ago, productive cough, in isolation until fever free for 72 hours. 4/3/20 at 6:39 P.M., Physician called orders to remain in isolation. 4/5/20 at 4:15 A.M., Currently complaining of a cough that is non-productive and dry. Remains in isolation until she is fever free for 72 hours. 4/6/20 at 10:15 P.M., Isolation until fever free for 72 hours. On 4/8/20 at 9:15 A.M., Resident J's room was observed to have a sign on the door that indicated STOP. Please stop at Nurse's station before entering and an isolation cart outside the room. On 4/8/20 at 9:20 A.M., Resident J's clinical record was reviewed. The Progress Notes, dated 4/7/20 indicated Resident J had an elevated temperature of 99.1 and a raspy cough. The physician ordered a Covid-19 test to be completed at a clinic in the community. On 4/8/20 at 9:55 A.M., CNA 56 indicated Resident J had a temperature and they were waiting on a Covid-19 test result. CNA 56 indicated if she entered the room, she would don a gown, N95 respirator, gloves, and shoe protectors. On 4/8/20 at 10:05 A.M., LPN 60 indicated Resident J had a temperature on the previous Friday (4/3/20) at 100 degrees Fahrenheit. LPN 60 indicated Resident J had been on isolation until she was fever free for 72 hours. LPN 60 indicated yesterday Resident J had a cough and a temperature and the physician ordered a Covid-19 test to be completed. LPN 60 indicated Resident J was on strict isolation for 14 days. At that time, LPN 60 verbalized how she donned and doffed her personal protective equipment when she entered the room on that morning (4/8/20). LPN 60 indicated she sanitized her hands, obtained a gown from the isolation cart, tied the gown, donned her N95 respirator and face shield, sanitized her hands, and donned gloves. LPN 60 indicated to remove her personal protective equipment, she pulled on her gown, rolled inward, removed her face shield with her gloved hand, reached for the doorknob on the inside with her gloved hand, continued to remove her gown and gloves, disposed of them in the trash inside the residents room, grabbed the hallway doorknob, removed her N95 respirator and threw it in the trash on her medication cart, and sanitized her hands, and donned a surgical mask. LPN 60 indicated she then went to the nearest hand washing sink (down the hall and around the corner from Resident J's room) and washed her hands. LPN 60 indicated there was hand sanitizer in the isolation cart but she was unsure if there was any in the room. On 4/8/20 at 10:20 A.M., 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. On 4/8/20 at 10:53 A.M., the DON indicated at this time Resident J would stay in her room. The DON indicated they had planned to utilize the North Unit for isolation but it was not ready yet. 2. On 4/7/20 at 11:55 A.M., the DON and CNA 52 were observed to be wearing surgical masks. The DON was observed to be walking down the hall. CNA 52 was preparing to deliver the noon meal to residents. The DON and CNA 52 did not have the surgical mask covering their noses. 3. On 4/6/20 at 7:25 P.M., Resident X and Resident Y were observed to have signs on the doors to their rooms which indicated, STOP. Please stop at Nurse's station before entering. Resident X and Resident Y's rooms were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155145	A. BUILDING _____ B. WING _____	**04/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WASHINGTON NURSING CENTER	**603 E NATIONAL HWY WASHINGTON, IN 47501**

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 -** Some	(continued... from page 3) directly across the hall from each other. No isolation carts were observed. LPN 1 indicated she did not know who was in isolation. LPN 1 was notified of Resident X and Resident Y's signage on the door. LPN 1 indicated at that time those residents were just in isolation because they came from the hospital. On 4/7/20 at 11:55 A.M., Resident W, Resident X, and Resident Y were observed to have signs posted on their doors which indicated, STOP. Please stop at Nurse's station before entering. No isolation carts outside of the rooms were observed and the doors to the resident rooms were observed to be open. On 4/7/20 at 1:35 P.M., the same was observed. On 4/7/20 at 1:40 P.M., Resident W's door was observed with the DON. The DON indicated the resident was in isolation following a return from the hospital. The DON indicated the resident was no longer in isolation. At that time, the DON indicated residents who were new admission or readmissions were on droplet and contact isolation for 72 hours once they came into the facility. The DON further indicated residents were encouraged to stay in their rooms but could be in common areas if they were 6 feet apart. Resident Y's door was observed at that time with the DON. The door to the resident's room was open and a stop sign was placed on the door frame. The DON indicated Resident Y was a new admission and was in isolation. The DON indicated she thought Resident Y had been in the facility longer than 72 hours but was not sure. At that time, Resident X's door was observed with the DON. Resident X's door was closed and a CNA was observed to exit the room. The DON indicated Resident X had a negative Covid-19 test prior to entry into the facility. The DON indicated that all three residents were off isolation but the signs had not been taken down. On 4/8/20 at 9:55 A.M., Resident W's sign on the door frame to see the nurse prior to entry was observed. No isolation cart outside the room was observed. Resident X and Resident Y's signs which indicated, STOP. Please stop at Nurse's station before entering were no longer posted. On 4/8/20 at 3:05 P.M., RN 60 indicated Resident W had just returned from the hospital again on 4/7/20. LPN 60 indicated the isolation cart was not present that morning. On 4/6/20 at 2:22 P.M., Resident W's clinical record was reviewed. Resident W had been readmitted to the facility from the hospital on [DATE]. A Progress Note, dated 3/29/20 indicated Resident W would be on isolation for 14 days. On 4/6/20 at 2:33 P.M., Resident X's clinical record was reviewed. Resident X was admitted to the facility on [DATE]. On 4/6/20 at 2:34 P.M., Resident Y's clinical record was reviewed. Resident Y was admitted to the facility on [DATE]. On 4/8/20 at 2:00 P.M., the DON provided a corporate email dated 4/1/20. The email reverenced the American Health Care Association/ National Center for Assisted Living Guidance: Accepting Admissions from Hospitals During COVID-19 Pandemic, revised 3/30/20. The guidance indicated it strongly urged facilities to begin creating separate wings, units or floors by moving current residents to handle admissions from the hospital and keep current residents separate if possible. The guidance further indicated if a resident had not been tested prior to admission with a negative result, they should assume they are positive. Handwritten notes on the email indicated Resident W, Resident X, and Resident Y were all kept in isolation for 14 days. On 4/8/20 at 3:15 P.M., the DON indicated she had told the surveyor the wrong information on 4/7/20. New admissions and readmission from the hospital should be on isolation for 14 days. 4. On 4/7/20 at 8:45 A.M., RN 2 was observed to obtain temperatures with a temporal thermometer for a surveyor and the SSD (Social Service Designee) prior to entry into the facility. RN 2 did not sanitize or clean the thermometer in between uses. The unclean thermometer surface touched both the surveyor's temple and the SSD's temple On 4/7/20 at 1:20 P.M., RN 2 was observed to obtain temperatures with a temporal thermometer for two surveyors prior to entry into the facility. RN 2 did not sanitize or clean the thermometer in between uses. The unclean thermometer surface touched both the surveyors' temples. On 4/7/20 at 1:40 P.M., the DON indicated the thermometer should be sanitized between uses. 5. On 4/8/20 at 3:00 P.M., during a tour of the facility, multiple residents were observed to be sitting at the door to their rooms facing the hallway. The residents were not observed to have anything covering their face. On 4/8/20 at 3:26 P.M., the DON indicated she was unaware of guidance from Centers for Medicare and Medicaid on 4/2/20, that instructed facilities to have residents cover their mouth and nose with a tissue or wear a cloth mask when staff was in the room. The DON indicated a facility physician had contacted her on 4/8/20 at approximately 11:00 A.M., indicating residents with roommates should wear masks. On 4/8/20 at 8:00 A.M., the CMS (Centers for Medicare and Medicaid) COVID-19 Long-Term Care Guidance, dated 4/2/20, indicated all residents should cover their mouths and nose with a tissue when facility staff were present in the room. The revised guidance further indicated residents should wear a mask when out of the room. 3.1-18(b)(1)