STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155503	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EXCEPTIONAL LIVING CENTER OF BRAZIL	501 S MURPHY AVE BRAZIL, IN 47834

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to follow CDC guidance during a pandemic and ensure infection control practices for COVID-19 were implemented to prevent the potential for spread of [MEDICAL CONDITION] after 6 dementia care unit employees tested positive for COVID-19 and residents began exhibiting symptoms of COVID-19, for 13 of 13 residents who resided on the dementia care unit. Contact droplet precautions were not implemented for 3 of 4 residents reviewed for infection control who had symptoms of COVID-19. Resident E on dementia care unit and Residents B and C who resided on a green unit (a unit that houses residents with low risk of infection/who have not been exposed) with 25 other residents. Four additional residents began to exhibit symptoms of COVID-19 on [DATE] (Residents H, J, K, and L). The Immediate Jeopardy began on [DATE], when Resident E had an elevated temperature and was not placed in isolation (special precautions to prevent the spread of germs). Resident E resided on the memory care unit, where there were six confirmed positive staff, with 12 residents. Residents B and C were observed residing on a green unit with no isolation precautions and symptoms of COVID-19. The Administrator and Director of Nursing were notified of the Immediate Jeopardy at 6:05 p.m., on [DATE]. The immediate jeopardy was removed on [DATE], but noncompliance remained at a lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Review of a Long Term Care Respiratory Surveillance Line List, provided by the Director of Nursing (DON) on [DATE], and a document with employees' positive result dates and days last worked, provided by the Executive Director (ED) on [DATE], indicated there were six staff members who worked on the memory care unit who tested positive for COVID-19: a. Employee 8 had Covid-19 symptoms on [DATE], was tested on an unknown date with positive results on [DATE]; and worked on [DATE], [DATE], and [DATE]. b. Employee 9 had Covid-19 symptoms on [DATE], was tested on [DATE] with positive results on [DATE]; and worked on [DATE], [DATE], and [DATE]. c. Employee 10 had Covid-19 symptoms on [DATE], was tested on [DATE] with positive results on [DATE]; and worked on [DATE], [DATE], and [DATE]. d. Employee 11 had Covid-19 symptoms on [DATE], was tested on [DATE], with positive results on [DATE]; and worked on [DATE], [DATE], and [DATE]. e. Employee 12 had Covid-19 symptoms on [DATE], was tested on [DATE] with positive results on [DATE]; and worked on [DATE], [DATE], and [DATE]. f. Employee 13 had Covid-19 symptoms on [DATE], was tested on [DATE] with positive results on [DATE]; and worked on [DATE], [DATE], and [DATE]. The CDC guidance, updated [DATE], - Responding to Coronavirus (COVID-19) in Nursing Homes, Responding to COVID-19: Considerations for the Public Health Response to COVID-19 in Nursing Homes indicated, .HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset .Prioritize these HCP for [DIAGNOSES REDACTED]-CoV-2 testing. Exclude HCP with COVID-19 from work until they have met all return to work criteria. Determine which residents received direct care from and which HCP had unprotected exposure to HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset .Residents who were cared for by these HCP should be restricted to their room and be cared for using all recommended COVID-19 PPE until results of HCP COVID-19 testing are known. If the HCP is diagnosed with [REDACTED].Exposed HCP should be assessed for risk and need for work exclusion .If testing is available, asymptomatic residents and HCP who were exposed to HCP with COVID-19 should be considered for testing (see information on testing below). If testing identifies infections among additional HCP, further evaluation for infections among residents and HCP exposed to those individuals should be performed as described above. During an interview on [DATE] at 2:35 p.m. the DON indicated there were currently 12 residents on the dementia care unit. 1. Resident E's record was reviewed on [DATE] at 12:15 p.m. [DIAGNOSES REDACTED]. A vital signs record, dated [DATE], indicated the resident's temperature was 99.0 degrees Fahrenheit (F). A vital sign record, dated [DATE], indicated the resident's temperature was 99.5 degrees F. A nurse's note, dated [DATE], indicated Resident E had been in bed and was lethargic. The resident's oxygen saturation (level of oxygen in the blood) was 92 percent and his temperature was 99.8 degrees F. The resident was put on oxygen at two liters (L) to improve the saturation. A nurse's note, dated [DATE], indicated the resident was on continuous oxygen at four liters related to a physician's orders [REDACTED]. Standard universal precautions were in place. A vital signs record, dated [DATE], indicated the resident's temperature was 98.9 degrees F. A physician's orders [REDACTED]. The physician's orders [REDACTED]. A nurse's note, dated [DATE], indicated the resident's oxygen saturation was in the 70 and 80 percentile range. Respirations were labored. A vital signs record, dated [DATE], indicated the resident's temperature was 99.0 degrees F. A nurse's note, dated [DATE] at 11:48 a.m., indicated the resident was not responsive, received oxygen at four liters through a Venturi mask (a mask to deliver oxygen), and the oxygen saturation was 80 percent. The physician and power of attorney (POA) were notified, and Hospice (specialized care for terminal patients) was consulted. A nurse's note, dated [DATE] at 11:20 p.m., indicated the resident's vital signs ceased. A Treatment Administration Record (TAR), dated [DATE], indicated the resident may have a COVID-19 test every three to seven days. The record indicated the resident was tested on [DATE]. Census information indicated the resident resided on the memory care unit and expired on [DATE]. A Bed Board, dated [DATE], indicated the resident had a roommate, Resident H. Nurse's notes, dated [DATE] to [DATE], lacked documentation the resident was placed in droplet isolation precautions related to symptoms of COVID-19. During an interview, on [DATE] at 9:43 a.m., the Administrator indicated the entire memory care unit was considered a red (a unit where all residents are infected with COVID-19 and require droplet isolation precautions) unit. During an interview, on [DATE] at 12:04 p.m., the Assistant Director of Nursing (ADON) indicated she was the Infection Preventionist (IP) for the facility. When the staff entered the room of any resident positive for COVID-19 they were required to wear personal protective equipment (PPE) including goggles, gowns, N95 masks, gloves, and shoe covers. Staff only used this PPE for the one positive resident on the memory care unit. For all other residents on the memory care unit, staff should have worn an N95 mask and gloves, but not a gown, goggles, or shoe covers. During an interview, on [DATE] at 2:50 p.m., the Director of Nursing (DON) indicated she thought the resident's symptoms and death were related to his heart condition. After review of the resident's symptoms and their facility policy for when to isolate, the resident should have been placed in droplet isolation precautions. The resident had not been isolated and had a roommate. During an interview, on [DATE] at 3:37 p.m., the DON indicated there were six employees of the facility who tested positive for COVID-19. All of them worked on the memory care unit. When the staff became positive for COVID-19 they changed their staff screening tool to include a symptom of loss of sense of taste or smell, made the memory care unit have its own entrance and exit, and initiated the use of N95 masks (a particulate filtering respirator) on the memory care unit. They had not changed anything regarding how the residents were screened or cared for with the new onset of staff positive cases. On [DATE], the facility tested all residents for COVID-19, but they had not received test results yet. On [DATE] at 2 p.m. the DON provided the updated LTC Respiratory Surveillance Line List and indicated Resident H, Resident E's roommate, was symptomatic with a cough as of [DATE]. During an interview, on [DATE], the Administrator indicated Resident E's test results were negative for COVID-19, but Resident H's test results were positive for COVID-19. 2. Resident B's record was reviewed on [DATE] at 10:54 a.m. [DIAGNOSES REDACTED]. A significant change Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had a severe cognitive impairment, wandering (moving throughout the facility without purpose) occurred four to six days of the

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) look back period, and required extensive staff assistance with bed mobility, transfers, dressing, and personal hygiene. A nurse's note, dated [DATE], indicated the resident was wandering that morning. A nurse's note, dated [DATE], indicated the resident was wandering that morning. An infection event, dated [DATE], indicated the physician ordered [MEDICATION NAME] (an antibiotic) for five days for a respiratory infection. Symptoms included runny nose or sneezing and stuffy nose or congestion. The event lacked documentation the resident was placed on droplet isolation precautions. A physician's orders [REDACTED]. physician's orders [REDACTED]. A nurse's note, dated [DATE], indicated the resident had green nasal drainage, cough, and diminished lung sounds. The physician was notified and ordered [MEDICATION NAME] for five days. The nurse's note lacked documentation the resident was placed in droplet isolation precautions. A care plan, initiated [DATE], indicated the resident received an antibiotic for URI. The care plan lacked documentation the resident required droplet isolation precautions. A Bed Board, dated [DATE], indicated the resident resided on a green unit, and had a roommate, Resident F. A Treatment Administration Record (TAR), dated [DATE], indicated the resident may have a COVID-19 test every three to seven days. The record indicated the resident was tested on [DATE]. A Physician's progress note, dated [DATE], indicated the resident had decreased lung sounds in the base of the lungs. The note lacked documentation the resident required droplet isolation precautions. A care plan, goal target dated [DATE], indicated the resident was at risk for COVID-19 exposure. Interventions included, but were not limited to, resident refused to wear a mask related to anxiety and would be encouraged to wear a mask, and observe for signs and symptoms of COVID-19 including fever, coughing, sneezing, sore throat, and respiratory issues. A care plan, goal target dated [DATE], indicated the resident wandered up and down hallway, and into other residents' rooms. During an interview, on [DATE] at 10:16 a.m., Registered Nurse (RN) 6 indicated Resident B had a runny nose, but was not considered suspicious for COVID-19. If a resident exhibited symptoms of COVID-19, they should have been placed in droplet isolation precautions. On [DATE] at 10:35 a.m., Resident B's room was observed with no isolation precautions in place. The resident had a roommate. On [DATE] at 11:32 a.m., Resident B was observed outside of his room on the green unit, with his mask pulled down underneath his nose. Qualified Medication Aide (QMA) 7 adjusted the residents mask, bare handed, then wiped her hand on her pants. During an interview, on [DATE] at 12:04 p.m., the Assistant Director of Nursing (ADON) indicated she was not aware Resident B had respiratory symptoms. The resident was not isolated because he had not had a fever. The resident wandered and was non-compliant with wearing a mask. During an interview, on [DATE], at 12:29 p.m., the Administrator indicated if a resident had a new onset of URI, they should have been placed in droplet isolation precautions. However, she thought if a resident did not have a fever, it was fine for them to be out of their room. During an interview, on [DATE] at 2:50 p.m., the Director of Nursing (DON) indicated she reviewed Resident B's chart and the policy for isolation, and he should have been isolated. The physician had diagnosed a URI, however, according to the facility policy, he should have been placed in droplet isolation precautions. The resident had a roommate. 3. Resident C's record was reviewed on [DATE] at 11:50 a.m. [DIAGNOSES REDACTED]. A five day admission Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact and required extensive assistance from staff for bed mobility, transfer, dressing, toilet use, and personal hygiene. A Treatment Administration Record (TAR), dated [DATE], indicated the resident may have a COVID-19 test every three to seven days. The record indicated the resident was tested on [DATE]. A Bed Board, dated [DATE], indicated the resident resided on a green unit, and had a roommate, Resident G. A Physician's progress note, dated [DATE], indicated the staff reported the resident was congested. The physical exam indicated the resident's chest and lungs were tight (diminished air flow) with fine crackles (fine, short, high-pitched crackling sounds can be caused from air passing through fluid, pus, or mucus) in the left lung fields. The assessment indicated the resident had a cough. The physician's plan included, but was not limited to, chest x-ray and COVID-19 testing this week, to be done for all residents. The note lacked documentation the resident required droplet isolation precautions. A physician's orders [REDACTED]. physician's orders [REDACTED]. A care plan, goal target dated, [DATE], indicated the resident was at risk for COVID-19 infection related to pandemic. Interventions included, but were not limited to, initiate isolation precautions immediately for presumptive symptoms. During an interview, on [DATE] at 10:16 a.m., Registered Nurse (RN) 6 indicated Resident C had new onset chest congestion, but was not suspicious for COVID-19. If a resident exhibited symptoms of COVID-19, they should have been placed in droplet isolation precautions. On [DATE] at 10:35 a.m., Resident C's room was observed with no isolation precautions in place. The resident had a roommate, Resident G. During an interview, on [DATE] at 12:04 p.m., the Assistant Director of Nursing (ADON) indicated she was the Infection Preventionist (IP). She was not aware Resident C had respiratory symptoms. She was not sure why the resident did not require droplet isolation precautions. She had not reviewed the resident's charting to determine if the resident required isolation. During an interview, on [DATE] at 12:29 p.m., the Director of Nursing (DON) indicated she thought residents with low oxygen saturation (level of oxygen in the blood), fever above 100.4 degrees Fahrenheit (F), or shortness of breath should have been placed in droplet isolation precautions. During an interview, on [DATE] at 1:02 p.m., the DON indicated they would follow CDC guidelines for what residents required droplet isolation precautions. After review of Resident C's charting and the facility policy, Resident C should have been placed in droplet isolation precautions. She was not notified the resident had symptoms of COVID-19. Symptoms should have been reported by facility staff to the DON and physician immediately. During an interview, on [DATE] at 1:10 p.m., RN 6 indicated she noticed Resident C had new onset chest congestion that morning when her shift started at 6:00 a.m., and she notified the physician between 6:30 a.m. and 6:45 a.m. The physician examined the resident later when he came into the facility. She had not notified the DON. On [DATE] at 2:00 p.m., the DON provided the updated LTC Respiratory Surveillance Line List. The list indicated 6 residents were identified as symptomatic during the audit on [DATE] (Residents B, C, J, K on 200 hall and Residents H and L on dementia care unit). Resident H, roommate to Resident E, was symptomatic with a cough as of [DATE]. During an interview, on [DATE], the Administrator indicated Resident C's test results were positive for COVID-19. 4. On [DATE] at 1:30 p.m., in the Yellow zone droplet isolation area, the doors to the rooms of Resident J, Resident K and Resident B were observed open with the residents in the rooms. On [DATE] at 5:50 p.m., in the Yellow zone droplet isolation area, the doors to the rooms of Resident J, Resident C, Resident K, and Resident B were observed open with the residents in the rooms. On [DATE] at 10:45 a.m., in the Yellow zone droplet isolation area, the doors to the rooms of Resident J, Resident M, Resident C, and Resident B were observed open with residents in the rooms. The DON indicated, she was not aware the isolation room doors should be closed to the isolation rooms. On [DATE] at 11:15 a.m., the Administrator indicated, they had updated the facility's policy to include that droplet isolation room doors were to remain closed at all times. On [DATE] at 1:02 p.m., the DON provided a document titled, Active Screening of Residents, and indicated it was the policy currently being used by the facility. The policy was attached to an email, dated [DATE], and lacked documentation it was updated since that date. The screening tool indicated, Evaluate residents for the following every 12 hours: Common Signs and Symptoms: Fever greater than or equal to 99.0 degrees F, Cough, Shortness of breath-increased oxygen requirements or increased frequency of nebulizer treatments may be surrogate symptoms of shortness of breath. Less common Signs and Symptoms: Confusion or change in mental status and if noted, check pulse oximetry to determine if increased oxygen requirements, Muscle aches, headache, Sore throat, runny nose, Chest pain, Diarrhea, nausea, vomiting. Probable case: any two of the common signs/symptoms-Initiate contact and droplet precautions. Check a room air pulse-oximetry. Increase frequency of vital signs, including pulse oximetry to every 8 hours. Screen for influenza. If negative, screen for COVID-19 (in areas of community outbreak may consider concomitant testing based on clinicians assessment). Possible case: any one of the common signs/symptoms and greater than or equal to 1 of the less common signs/symptoms-Initiated contact and droplet precautions. Check a room air pulse-oximetry. The CDC guidance - Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, indicated, Evaluate and Manage Residents with Symptoms of COVID-19 .Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 .Actively monitor all residents upon admission and at least daily for fever (T 100.0oF) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below .Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0oF might also be a sign of fever in this population . Identification of these symptoms should prompt isolation and further evaluation for COVID-19 During staff interviews on [DATE], Employee 7, Employee 16, and Employee 17 indicated they had received in-services on isolation precautions, and to watch for signs or symptoms of COVID including abnormal temperatures of more than 100.3 degrees Fahrenheit. The ISDH Guidance for out-of-hospital facilities, dated [DATE], indicated, The following is guidance for out of hospital facilities who house

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) patients with a confirmed or suspected case of COVID-19. There are a few guiding principles: 1. Placement of patient /resident in contact-droplet precautions with proper PPE, including gown, glove, mask with face shield or eye protection. 2. Proper donning and doffing of personal protection equipment when in contact with COVID-19 residents Reduce the movement of staff between patients with and without COVID-19 precautions with proper PPE- gown, glove, mask with face shield or eye protection .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 . Patients with close contact with a confirmed COVID-19 patient (e.g., roommate or infected staff without wearing PPE) should be isolated and follow 14 day self-monitoring guidelines. If they develop symptoms, and are confirmed or suspected to have COVID-19, they should remain isolation until at least 7 days after symptom onset and 72 hours after resolution of fever, without use of antipyretic medication, and improvement in symptoms (e.g., cough), whichever is longer The CDC guidance, updated [DATE], - Responding to Coronavirus (COVID-19) in Nursing Homes, Responding to COVID-19: Considerations for the Public Health Response to COVID-19 in Nursing Homes, indicated, .Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections .Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms .Counsel all residents to restrict themselves to their room to the extent possible .HCP should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents .If testing is available, asymptomatic residents and HCP who were exposed to the resident with COVID-19 (e.g., on the same unit) should be considered for testing The CDC guidance - Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, indicated, If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community, Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom. Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario. Public health authorities can assist with decisions about resident placement .If a resident requires a higher level of care or the facility cannot fully implement all recommended precautions, the resident should be transferred to another facility that is capable of implementation. Transport personnel and the receiving facility should be notified about the suspected [DIAGNOSES REDACTED].g., kept in their room with the door closed). Appropriate PPE should be used by healthcare personnel when coming in contact with the resident During a telephone interview, on [DATE], the Administrator indicated the results of the resident testing had come back and an additional 5 residents had positive results for COVID-19, four residents resided on the dementia unit and one resident was on the yellow isolation unit after being identified as symptomatic during the survey. The immediate jeopardy that began on [DATE] was removed on [DATE] when the facility reviewed all residents and residents with symptoms/known exposure were tested and placed in isolation with appropriate door signage and orders for isolation. Staff were reeducated on the isolation policies and procedures, and a plan was created to monitor for isolation procedures for residents with symptoms/pending tests or known exposures. The noncompliance remained at a lower 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 for continued monitoring. 3XXX,[DATE](a)