STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. BUILDING _____ B. WING _____	06/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY RD BROWNSBURG, IN 46112

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 and interview, the facility failed to follow CDC guidance during a pandemic and ensure infection control practices for COVID-19 were implemented for residents with symptoms of COVID-19 (Resident F and Resident C) who resided with asymptomatic roommates (Resident L and Resident K), and another resident with symptoms of COVID-19 who was not placed on isolation precautions (Resident B), resulting in potential exposure of other residents and staff to COVID-19, for 5 of 10 residents reviewed for infection control, and who resided on the 400 hall, which housed 12 residents as of [DATE] The Immediate Jeopardy began on [DATE], on the 400 hall, when Resident F was having symptoms of COVID-19, including congestion, wheezing, and low oxygen saturation (O2) at 75 percent (%) with no isolation precautions (special precautions to prevent the spread of germs) put into place. The resident remained in a room with Resident L who lacked documentation of symptoms of COVID-19. Resident C was found to have symptoms of COVID-19 and remained in a room with Resident K, who lacked documentation of symptoms of COVID-19. Resident B had symptoms of COVID-19 and was not placed on isolation precautions. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy at 4:45 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: 1a. Resident F's record was reviewed on [DATE] at 4:32 p.m. [DIAGNOSES REDACTED]. A progress note, dated [DATE] at 8:37 p.m., indicated the resident had wheezed and was congested. O2 saturations (the amount of oxygen in the blood - normal is greater than 90%) at 75% on 2 liters per minute (LPM) of oxygen via nasal cannula. The O2 was increased to 3 LPM, and O2 saturations remained in low 80's. The Nurse Practitioner (NP) was notified and new orders were received to obtain labs and chest x-ray the next day. The progress note lacked documentation the resident was placed on isolation precautions. A review of physician's orders [REDACTED]. A progress note, dated [DATE] at 10:13 a.m., indicated the Nurse Practitioner (NP) requested a COVID-19 test, and the resident was moved to an isolation room. A progress note, dated [DATE] at 3:28 a.m., indicated the resident had deceased . A progress note, dated [DATE] at 1:23 p.m., indicated the resident's wife had been notified the COVID-19 test was positive. 1b. Resident L's record was reviewed on [DATE] at 4:28 p.m. [DIAGNOSES REDACTED]. The resident's record, dated [DATE] to [DATE], lacked documentation the resident had been placed on isolation precautions, after being exposed to the resident's roommate, Resident F, who was having symptoms of COVID-19 beginning on [DATE]. A vitals summary, dated [DATE] at 1:16 p.m., indicated the resident had a temperature of 101.1 degrees Fahrenheit. During an interview, on [DATE] at 2:25 p.m., the DON indicated Resident F had symptoms documented [DATE] and was moved into isolation the next day. They had felt the resident had aspirated and did not have symptoms of COVID. The DON indicated per the daily census, on [DATE], Resident F resided in a room with Resident L. On [DATE] the 400 unit hall was placed on isolation precautions, on [DATE] Resident L was tested for COVID-19, and results had not been received at this time. During an interview, on [DATE] at 1:20 p.m., the Regional Director indicated Resident F was not moved to a single room immediately because the facility had to obtain permission from the family and a room had to be deep cleaned. Resident F's wife had not wanted the resident moved because he had the same roommate for a long time and did not want the resident alone. Confidential interviews were conducted during the course of the survey. The interviewee indicated Resident F had low oxygen saturations and wheezing on [DATE]. The resident was placed on isolation precautions on [DATE]. The resident resided in a room with Resident L and was Resident L was not placed on isolation precautions, only gloves and masks were used for Resident L. The DON had indicated not to move Resident F into a private room. There were no standing orders in place for isolation precautions when a resident was symptomatic of COVID-19. The staff would contact the DON if a resident was symptomatic and needed placed in isolation precautions. Confidential interviews were conducted during the course of the survey. The interviewee indicated there were no standing orders in place for isolation precautions when a resident was symptomatic of COVID-19. 2. Resident B's record was reviewed on [DATE] at 1:23 p.m. [DIAGNOSES REDACTED]. A progress note, dated [DATE] at 6:21 p.m., indicated the resident had vomited and then felt better. The resident's temperature was obtained and was 100.9 degrees Fahrenheit, and a few minutes later temperature was retaken and at 101.1 degrees Fahrenheit. The resident was administered two tablets of Tylenol. The record lacked documentation the resident was placed on isolation precautions. A progress note, dated [DATE] at 8:04 p.m., indicated the resident had vomited before he ate pizza and he felt fine. Resident's family member was called and family member requested the resident be tested for COVID-19. A respiratory surveillance line list, onset date [DATE], indicated the resident had a fever and nausea. A review of physician's orders [REDACTED]. A physician note, dated [DATE] at 10:10 a.m., indicated the resident visit had been requested by the resident's family. Resident was seen for vomiting two days over the past three days. Upon exam, the resident appeared to feel unwell with mild noted pallor but per resident had been feeling better. Resident had increased fatigue and confusion the last two days. Low grade temperature was treated on [DATE]. The note indicated the resident would be monitored closely with respiratory evaluation and temperature monitoring frequently throughout the day. A progress note, dated [DATE] at 12:59 p.m., indicated the writer had spoken with daughter and per her request the resident had been tested for COVID-19. A progress note, dated [DATE] at 5:00 p.m., indicated the resident reported being cold and nauseated. Temperature was 101.8 degrees Fahrenheit. The NP was notified and nurse was instructed to call family and ask which hospital to send resident to. Resident was transported to hospital and admitted . A progress note, dated [DATE] at 4:39 a.m., indicated the daughter called to inform the facility her father had passed away. A laboratory document, dated [DATE], indicated the COVID-19 specimen, collected on [DATE], was pending. During an interview, on [DATE] at 10:52 a.m., Resident B's family member indicated the resident had a fever on [DATE] and on [DATE] had a fever and vomited. The resident was sent to the hospital on [DATE] and a COVID-19 test was obtained and came back positive. He was placed on a ventilator on [DATE] and passed away on [DATE]. During an interview, on [DATE] at 2:06 p.m., the DON indicated Resident B had vomited on [DATE], and the resident had indicated he felt it was from lunch he had eaten at the facility and pizza brought in by family that upset his stomach. The resident later spiked a temperature and was treated with Tylenol and resolved. The resident had no other symptoms. The facility had not felt he required isolation precautions at that time. No other symptoms were noted until [DATE] and the resident was sent to the hospital. She was unsure if the policy specified when a resident had signs or symptoms of COVID-19 when the resident should be placed on isolation precautions. 3a. Resident C's record was reviewed on [DATE] at 3:14 p.m. [DIAGNOSES REDACTED]. A progress note, dated [DATE] at 1:20 p.m., indicated the resident had a fever of 100.3 degrees Fahrenheit and malaise. The Nurse Practitioner was notified and new orders for chest x-ray and COVID-19 testing were received. A daily census form, dated [DATE], indicated Resident C was in a semiprivate room and had a roommate, Resident K. A progress note, dated [DATE] at 6:32 a.m., indicated per policy the resident would be moved to a separate room today. 3b. Resident K's record was reviewed, on [DATE] at 2:32 p.m. A progress note, dated [DATE] at 1:16 a.m., indicated the resident had not eaten or drank well, was more confused, and had a temperature of 102.5 degrees Fahrenheit. The resident resided in a secured location with isolation precautions in place. A COVID-19 test was pending. During an interview, on [DATE] at 2:25 p.m., the DON indicated Resident C had developed symptoms on [DATE] and was not moved to a private room until [DATE] because they had to wait for a private

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) room to be deep cleaned. Resident C's roommate (Resident K) was asymptomatic on [DATE]. She indicated 81 residents had been tested for COVID-19 on [DATE]. During an interview, on [DATE] at 1:06 p.m., Certified Nursing Assistant (CNA) 5 indicated the staff used standard precautions with all residents and wore masks. If a resident had symptoms of COVID-19 or had tested positive, the resident would be placed on droplet isolation precautions and would be placed in a private room. Personal Protective Equipment (PPE) for suspected or confirmed COVID-19 consisted of gloves, mask, gown, and a shield or goggles. PPE equipment would be placed outside of a resident's room and the staff would be made aware if a resident was on isolation precautions for COVID-19. During an interview, on [DATE] at 2:25 p.m., the DON indicated staff were only wearing face masks and gloves in the residents' rooms until the residents were placed on droplet isolation. The DON indicated the entire 400 unit hall was placed on isolation precautions on [DATE]. The DON did not indicate there were standing order sets from the physician for isolation. The DON did not indicate Residents F, L, C, K, or B were placed on isolation utilizing the standing order sets for isolation. On [DATE] at 4:45 p.m., the Administrator and DON were informed of the immediate jeopardy. The DON and the Administrator did not indicate there were standing order sets from the physician for isolation. They did not indicate Residents F, L, C, K, or B were placed on isolation utilizing the standing order sets for isolation. During an interview, on [DATE] at 2:44 p.m., the DON provided standing orders for isolation for residents with symptoms of COVID- 19. The DON indicated they had standing orders in place and all residents if symptomatic for COVID-19 were placed on isolation precautions. She had forgotten to mention these orders on [DATE]. A signed document from (name of physician's office), with date of [DATE], indicated, Standing Protocol Order for Covid Signs and Symptoms: 1) Any resident with respiratory, or Covid signs and symptoms are to be placed in droplet isolation .4) Contact provider for notification of initiation of protocol, additional orders, or changes in status. On [DATE] at 4:21 p.m., the Administrator provided a document titled, Disaster Preparedness, and indicated it was the policy currently being used by the facility. The policy indicated, .37. The facility will co-hort residents per the CDC isolation criteria. Residents exhibiting new onset of respiratory illness are isolated until the medical [DIAGNOSES REDACTED]. Full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance On [DATE] at 4:21 p.m., the Administrator provided a document titled, Indiana Nursing Home Infection Prevention Assessment Tool for COVID-19, and indicated it was the policy currently being used by the facility. The policy indicated, The following infection prevention and control assessment tool should be used to assist nursing homes with preparing to care for residents with COVID-19 .Identify infections early: actively screen all residents at least daily for fever and respiratory symptoms; immediately isolate anyone who is symptomatic. Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include: new or worsening malaise, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 if it is widespread in the community The ISDH Guidance for out-of-hospital facilities, dated [DATE], 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: 1. Placement of patient /resident in contact-droplet precautions with proper PPE, including gown, glove, and 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, and 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. Airborne infection isolation rooms (AIIR) are not required. 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. 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 in 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 - 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 . The immediate jeopardy that began on [DATE] was removed on [DATE] when the facility reviewed all residents and residents with symptoms/known exposure and/or positive results were 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. This Federal tag relates to Complaint IN 598. 3XXX,[DATE](a)