STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING _____ B. WING _____	06/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN 46552

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, interview and observations, the facility failed to ensure infection control practices were followed during a pandemic for residents with symptoms of COVID-19 and/or exposure to positive COVID-19 residents for 2 of 3 residents reviewed for infection control (Residents B and C). These lack of infection control practices place other residents in the facility at risk of being exposed to the COVID-19 virus. The immediate jeopardy began on 6/4/2020 when the facility failed to ensure infection control practices for COVID-19 were followed when Resident B was experiencing symptoms of COVID-19 and no isolation precautions were put into place. Resident B continued to room with Resident C at that time. The Executive Director, Director of Nursing, Assistant Director of Nursing, and Director of Clinical Services were notified of the immediate jeopardy at 3:56 P.M. on 6/10/2020. The immediate jeopardy was removed on 6/12/2020, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. The record for Resident B was reviewed on 6/10/2020 at 11:00 A.M. The [DIAGNOSES REDACTED]. A progress note, dated 6/4/2020 at 3:55 P.M., indicated Resident B had a non-productive cough, lungs sounds were diminished and wheezing was noted. The resident's temperature was 99.8, oxygen saturation (the amount of oxygen in the blood - normal is 90% or greater) was 90% and the physician was notified. A progress note, dated 6/4/2020 at 6:27 P.M., indicated Resident B had a temperature of 99.0 and no reply from the physician yet. A progress note, dated 6/4/2020 at 8:30 P.M., indicated Resident B had a nonproductive cough, and oxygen saturation was 87% on room air. The resident was placed on 2 liters of oxygen per nasal cannula, and a stat chest x-ray was ordered. A chest x-ray, dated 6/4/2020 at 10:41 P.M., indicated right basilar airspace disease, recommend follow up examination to confirm resolution findings. A progress note, dated 6/5/2020 at 9:25 A.M., indicated a new order was received for resident to be moved to private room on the skilled unit instead of staying in his current room. COVID-19 test was ordered, and the resident was started on [MEDICATION NAME] (antibiotic). An infectious disease lab report, dated 6/5/2020 at 11:50 A.M., indicated Resident B was positive for COVID-19. A physician note, dated 6/7/2020 at 8:00 P.M., indicated the physician was called to evaluate the resident due to respiratory distress and recent COVID-19 testing. The note indicated the resident was started on [MEDICATION NAME] for possible aspiration due to history. Assessment and plan indicated COVID-19 positive with [MEDICAL CONDITION]. A progress note, dated 6/7/2020 at 10:18 P.M., indicated Resident B tested positive for COVID-19. The ED (Executive Director), ADON (Assistant Director of Nursing), physician and power of attorney were notified. Resident was being transferred to designated isolation unit. Full PPE (protective personal equipment), including N95 mask, goggles, face shield, hair covering, gown and gloves were worn by staff during transfer. N95 mask, face shield, gown, and gloves were also placed on the resident during transfer. Full supply of all PPE, resident care supplies, state and federal, and OSHA approved and required cleaning and sanitizing chemicals with MSDS and placed into isolation, and policies and procedures inside COVID unit. Oxygen supplies with backups on hand as resident is currently on 3 liters of oxygen per nasal cannula. Orders received from physician per power of attorney to discontinue all medications and place resident on comfort measures only. Full PPE was worn by designated COVID unit healthcare staff at all times. A progress note, dated 6/8/2020 at 5:40 A.M., indicated Resident B showed accelerated decline. A progress note, dated 6/8/2020 at 10:15 A.M., indicated Resident B was absent of all vital signs, no sign of life, pupils fixed and dilated. During an anonymous interview, it was indicated Resident B presented with puffy eyes and a cough on 6/3/2020. The on-duty nurse did an internet search to see if the symptoms that presented were associated with COVID-19. It was indicated the cough did not sound like a COVID cough because it was not persistent. The next day Resident B's cough became more persistent and his oxygen level was 86% on room air. The resident's physician/facility Medical Director was notified to see if she wanted him sent out around 8:30 P.M. The physician declined sending resident out and ordered a chest x-ray. There was no isolation in place for Resident B. An email to the Director of Nursing from the Nurse Practitioner (NP) dated 6/10/2020 at 7:21 P.M., indicated the NP was the on-call provider, and was called by the nurse on 6/4/2020 around 8:00 P.M. The NP was notified that Resident B was experiencing a mild cough and decreased oxygen saturation around 87% on room air. The nurse placed the resident on oxygen and oxygen saturation increased to 98%. Per nursing, he was not exhibiting any shortness of breath, was afebrile, no fatigue and no gastrointestinal symptoms. She was concerned with fluid overload or possible early pneumonia. During an interview, on 6/10/2020 at 4:00 P.M., the Assistant Director of Nursing (ADON) and Director of Nursing (DON) indicated COVID-19 testing was not requested because symptoms did not present as COVID-19 on 6/4/2020. When interviewed on 6/11/2020 at 11:29 A.M., the NP (Nurse Practitioner) indicated no orders were given for isolation on 6/4/2020. She indicated she was the NP on call for 6/4/2020. The physician order [REDACTED]. Confidential interviews were conducted during the course of the survey. During anonymous interviews, staff indicated they were not aware of the type of isolation required for presumed COVID-19 positive residents. During an interview, on 6/11/2020 at 10:58 A.M., the ADON indicated Resident B was not moved to the COVID unit on 6/5/2020 due not having staff available to work on that unit. There were no other residents residing on the COVID Unit. She indicated there was not dedicated staff to provide care for Resident B, and that may be a recommendation by CMS, but everyone knows that is impossible. During an interview, on 6/11/2020 at 1:13 P.M., the ADON indicated the symptoms that Resident B was exhibiting on 6/4/2020 were potential symptoms of COVID-19, and she indicated the NP should have been notified of increased temperature and other symptoms documented on 6/4/2020. 2. The record for Resident C was reviewed on 6/10/2020 at 11:30 A.M. The [DIAGNOSES REDACTED]. A progress note, dated 5/29/2020 at 8:34 P.M., indicated Resident C was sent to the local emergency room (ER) for increased blood sugar of 556 that had climbed after one hour. An ER physician report, dated 5/29/2020, indicated the resident presented with high blood sugar and was discharged back to the facility. During an anonymous interview, it was reported that staff expressed concern about placing the resident returning from ER back in a room with a roommate, and staff had communicated their concern to the Director of Nursing. A physician progress notes [REDACTED]. Assessment and plan for exposure to COVID-19 was to closely monitor for any signs and symptoms and COVID-19 testing. An ER physician report, dated 6/8/2020, indicated Resident C had been transported to the ER with concern of [MEDICAL CONDITION] today, oxygen saturation was 85% on room air and arrived on 6 liters of oxygen by nasal cannula. Resident was current resident at nursing home and apparently his roommate just tested positive for COVID-19. There was high suspicion for COVID-19. An immunology report, dated 6/8/2020, indicated Resident C was positive for COVID-19. During an interview, on 6/9/2020 at 4:36 P.M., the DON and ADON indicated the resident had been allowed to return to his room with roommate present upon return from hospital, because PPE had been worn by resident and all personnel that provided care during transport and at the local hospital. During confidential interviews, multiple staff members indicated aides have not been wearing masks and at times supplies have been scarce in the facility. It was reported that CNA 2 (certified nurse aide) had tested positive recently for COVID-19 and did not wear her mask when she worked about a week before she was diagnosed . They indicated there were days no masks were worn by staff and some wore them under their chin. Nurses indicated they would ask aides to put masks on, and some would ignore them and some put them on. They indicated they felt the CNAs were not taking the COVID-19 pandemic seriously. It was reported to a nurse that staff does not wear their

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) masks on the weekends. One staff member indicated, I am not going to lie, I am one of the ones that doesn't wear it. It was reported that nursing staff on the weekend had been observed not wearing masks. Staff indicated, it is hard for them to make us wear them, when they don't. It was reported that residents had been out of their rooms in the common area recently, with no masks. Concern was expressed due to a resident who recently tested positive for COVID-19 and was always in close contact with another resident out in the common area. During an interview, on 6/9/2020 at 4:36 P.M., the ADON indicated there are no managers on duty over the weekends to ensure masks are being worn and infection control is being maintained. She indicated the floor staff nurses on the weekends were shift managers to ensure masks were being worn. During an interview, on 6/10/2020 at 9:25 A.M., the Medical Director indicated the COVID-19 spread was not directly related to improper mask wear. She stated that it is hard for staff to wear a mask appropriately for long durations. During an interview, on 6/10/2020 at 12:00 P.M., the housekeeper on the East Unit indicated residents have been allowed out of their rooms for the past few days, and meals were being served in the common area. On 6/10/2020 at 9:35 A.M., the ADON provided the Indiana Back on Track Plan for Long Term Care Facilities and indicated this is what they used to determine if Resident C could go back in his room with a roommate upon return from the local emergency room . It indicated the decision to place the resident in transmission based precautions (contact-droplet) upon return for 14-day monitoring of signs and symptoms of respiratory infection should be made by the facility with consideration for the type of appointment (e.g. close contact), the availability and use of appropriate PPE by resident and providers, and the frequency of leaving the facility. On 6/10/2020 at 9:35 A.M., the ADON provided a CMS memo QSO-20-28-NH, dated 4/24/2020, and indicated this is what they used to determine if Resident C could go back in his room with a roommate upon return from the local emergency room . The memo indicated the facility should monitor the resident upon return for signs and symptoms of respiratory infection for 14 days after the outside appointment (preferably in a space dedicated for observation of asymptomatic residents). On 6/11/2020 at 12:35 P.M., the ADON provided, Consideration for Admission/Readmission during COVID Pandemic, dated 5/2020, and indicated this is the policy currently be used by the facility. The policy indicated newly admitted and readmitted residents should be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE (personal protective equipment.) On 6/11/2020 at 12:35 P.M., on 6/11/2020 at 12:35 P.M., the ADON provided the Signs and Symptoms of COVID policy, dated 5/2020, and indicated this is the policy currently be used by the facility. The policy indicated signs of COVID to observe for were fever/chills, cough, shortness of breath or difficulty breathing, fatigue, muscle aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea/vomiting, and/or diarrhea. The policy indicated residents will be placed in contact-droplet precautions when identified as symptomatic. On 6/11/2020 at 12:35 P.M., the ADON provided the Isolation of COVID positive and suspected COVID residents policy, dated 5/2020, and indicated this is the policy currently be used by the facility. The policy indicated residents who are identified as having symptoms of COVID-19 will be placed in contact-droplet precautions. Residents will be placed in a single room, if possible, while awaiting results. Roommates of residents with COVID-19 should be considered exposed and potentially infected. On 6/9/2020 at 3:15 P.M., the ADON provided a resident of list of COVID-19 cases in the facility: 5 suspected cases, 7 confirmed cases, 1 currently in hospital confirmed, and 1 death. During an interview, on 6/9/2020 at 3:15 P.M., the ADON indicated only one staff member was confirmed positive for COVID-19. The staff member was tested on [DATE] and notified the facility of results on 6/7/2020. During an interview, on 6/9/2020 at 9:10 A.M., the ADON indicated the staff member who had tested positive had worked three shifts from 5/24/2020 through 5/26/2020. The staff member worked on all units: West, East, Center and Skilled. The staff member had not worked since 5/26/2020. The CDC's Preparing for COVID-19 in Nursing Homes, dated as last updated 5/19/2020, included the following: HCP (Health Care Personnel) should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required. Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Implement Social Distancing Measures - Implement aggressive social distancing measures (remaining at least 6 feet apart from others): Cancel communal dining and group activities, such as internal and external activities. Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene. Remind HCP to practice social distancing and wear a facemask (for source control) when in break rooms or common areas. The immediate jeopardy that began on 6/4/2020 was removed on 6/12/2020 when the facility completed education on COVID-19 that included signs and symptoms, isolations requirements, and mask wearing to prevent the spread of [MEDICAL CONDITION], but the noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the need for continued education and monitoring. 3.1-18(a)