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	155530	A. BUILDING 00 B. WING	12/09/2021

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SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

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F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00368213. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00368213 - Substantiated. No deficiencies related to the allegations are cited. Survey date: December 9, 2021 Facility number: 000369 Provider number: 155530 AIM number: 100275190 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 9 Medicaid: 69 Other: 4 Total: 82 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/10/21.	F 0000		
F 0880 SS=F Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the			

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	facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to the lack of protective eyewear worn by staff during random observations. This had the potential to affect all residents residing in the facility. Finding includes: On 12/9/21 at 9:39 a.m., the Nurse Practitioner (NP) was observed entering an isolation room. She had an N95 mask on, but no eye protection. She exited the room at 9:43 a.m. without eyewear on. There was a sign on the door of the room that indicated the resident was on contact	F 0880	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey re-visit on or after **12/26/21** A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR §	12/26/2021

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	and droplet precautions and eyewear was required. Interview with the NP at that time indicated she was not aware she should have eye protection on. On 12/9/21 at 9:46 a.m., Housekeeper 1 was observed standing in the main hall. He was not wearing eye protection and there were residents present in the hall. Interview with the housekeeper at that time, he indicated he had eyewear, and pointed to a pair of splash guard glasses hanging on his shirt. On 12/9/21 at 9:48 a.m., while speaking to the Administrator in the main hall about staff not using eye protection, a staff member not wearing eye protection passed by pushing a resident in a wheelchair. The facility's county COVID-19 Community Transmission was High per the CDC (Center for Disease Control) on 12/1/21. The Indiana Department of Health COVID-19 Infection Control Guidance in Long-term Care Facilities updated 11/22/21, indicated, "...For substantial or high community transmission, then eye protection should be used by all HCP for all residents within 6 feet when delivering essential direct care regardless of COVID-19 status..." "...Eye protection should be close to face with no gaps at top, bottom, or sides of eyes...." 3.1-18(b)		488.424 effective December 26th, 2021. South Shore Health and Rehabilitation Center must include the following in their POC for the deficient practice cited at F880: **A. Specific/Immediate: Immediately implement specific plan for resident/residents/area/others identified in the deficiency to correct.** 1). The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff on how and when to utilize eye protection properly. All staff will be educated on proper eye protection and when it is required to be worn. NP educated on use of PPE in isolation rooms and use of eyewear in facility. **A. Systemic** 1). A root cause analysis (RCA) was conducted by the facility with input and review from the Medical Director, IP, Executive Director, Director of Nursing, Director of Clinical Operations and Corporate Nurse Consultant to determine the root cause resulting in the facilities Infection Control citation. a). Through staff interviews, it was determined that staff developed a misunderstanding from education provided related to the use of proper eye protection and when staff are required to	

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			wear it. The facility leadership team failed to ensure full implementation of continuous mandatory PPE requirements through clear education and direct observation – Staff must wear proper eye protection within 6 feet when delivering essential direct care regardless of COVID-19 status due to high transmission and county positivity rates Lack of staff understanding that eye protection should be used by all HCP for all residents within 6 feet when delivering essential direct care regardless of COVID-19 status NP lacked understanding of appropriate PPE to be used in resident care areas and isolation rooms b). The solutions and systemic changes developed by the Division (Consultant IP), DON, ADON and facility IP include: The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff on: Staff must wear proper eye protection within 6 feet when delivering essential direct care regardless of COVID-19 status due to high transmission and county positivity rates For this education and return demonstration, the following resources will be used: • CDC Guidance: Use	

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			Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 • CDC Guidance: Interim Infection Prevention and Control • CDC Guidance: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic The DON, IP or Designee will ensure all staff involved are educated on the need to wear appropriate eye wear The DON, IP, or designated facility leadership will conduct full / all department facility rounds at a minimum of daily to ensure staff are wearing eye wear appropriately while in the facility and enforce corrective measures and education if deficiencies are observed. 2). The DON, IP Nurse, Corporate Nurse Consultant and Director of Clinical Operations reviewed the LTC Infection Control Self-Assessment. Changes were made to so the assessment would now be an accurate reflection of the facility. This assessment will be submitted with the DPOC documentation. **C. Training:** 1).Per the LTC infection control	

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			assessment review and revision by The DON, IP Nurse, Corporate Nurse Consultant and Director of Clinical Operations, The following training needs were identified and implemented by the Division (Consultant) IP to the facility IP and DON with training resources and polices provided and submitted as part of the DPOC documentation. · Use of Eyewear in the facility The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff on how and when to don and doff eye protection. For this education and return demonstration, the following resources will be used: · CDC Guidance: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 · CDC Guidance: Interim Infection Prevention and Control · CDC Guidance: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic The DON, IP or Designee will ensure all staff involved are educated on the need to wear	

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			appropriate eye wear The DON, IP or Designee will post the CDC Guidance: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 for visual reminders for staff **D. Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained.** The DON, IP, or designated facility leadership will conduct full facility / all department rounds at a minimum of daily for 6 weeks and until compliance is maintained: to ensure staff are wearing eyewear appropriately while in the facility and enforce corrective measures and education if deficiencies are observed The DON, IP, or designated facility leadership will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and ensure staff are wearing eyewear appropriately. This will occur for 6 weeks and until compliance is maintained. **E. Quality Assurance and Performance Improvement (QAPI):** The IP Nurse/Director of Nursing will present the results of these	

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			audits monthly to the QAPI committee for no less than 6 months. The facility through the QAPI program will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0886 SS=E Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of			

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	asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in			

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	testing efforts, such as obtaining testing supplies or processing test results. Based on record review and interview, the facility failed to conduct COVID-19 testing for staff per guidelines for 3 of 3 staff records reviewed. (CNA 1, Activity Aide 1 and Nurse 1) Finding includes: The employee COVID-19 testing records, for the past four weeks, were reviewed on 12/9/21. Three unvaccinated staff members, CNA 1, Activity Aide 1 and Nurse 1, were selected for review. There was no evidence in the testing logs the three staff members had been tested for COVID-19. The Indiana Department of Health document, "Long-term Care COVID-19 Clinical Guidance", updated 9/7/21, testing table indicated when community COVID-19 activity was high, greater than 10% positivity rate, unvaccinated staff should be tested a minimum of two times weekly. Interview with the Infection Prevention Nurse on 12/9/21 at 1:39 p.m.., indicated the county positivity rate was high and unvaccinated staff were being tested twice weekly. She was unable to locate testing results for CNA 1, Activity Aide 1 or Nurse 1. 3.1-18(b)	F 0886	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey re-visit on or after **12/26/21** F886- South Shore **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All unvaccinated staff have been COVID tested. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents had potential to be affected by alleged deficient practice. All staff and residents were tested for COVID 19 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	12/26/2021

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			DON/IP educated on COVID 19 testing procedure with emphasis that all unvaccinated staff are to be tested per Long- Term Care COVID 19 Clinical Guidance. All unvaccinated staff educated on COVID 19 testing requirements **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/ IP or designee will be responsible for the completion of the Weekly COVID 19 testing log. The Weekly COVID testing log Audit tool will be completed twice weekly x 4 for one month, weekly x 4 for one month and then monthly for 4 months. The QAPI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	