STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. Survey dates: May 28, 2021 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 95 Total: 95 Census Payor Type: Medicare: 11 Medicaid: 57 Other: 27 Total: 95 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/1/21.	F 0000		
F 0880 SS=D 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. §483.80(a) Infection prevention and control program. The facility must establish an infection			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	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 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			

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	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 to prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn properly by staff when entering transmission based precaution (TBP) rooms for random observations for infection control. (Housekeeper 1, RN 1, and CNA 1) Findings include: On 5/28/21, the follow were observed on the 100 and 200 units: a. At 9:35 a.m., Housekeeper 1 was observed cleaning room 109. There was signage on the door that indicated the resident was on TBP, and an isolation cart was outside the room. The housekeeper had a face shield, mask and gloves on, but was not wearing a gown.	F 0880	**Aperion- Tolleston Park** **POC Infection Control Survey** **Exit 05/28/2021** **Compliance 06/14/2021** **F880 Infection control**	06/14/2021

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	b. At 9:45 a.m., RN 1 entered room 112 and stood bedside speaking to the resident for a couple minutes. The RN had a face shield and a mask on, she was not wearing gloves or a gown. There was signage on the door that indicated the resident was on TBP, and an isolation cart was outside the room. c. At 9:50 a.m., CNA 1 was observed entering room 230 with a meal tray. She set up the meal tray while talking to the resident. The CNA had a face shield and a mask on, she was not wearing gloves or a gown. There was signage on the door that indicated the resident was on TBP, and an isolation cart was outside the room. The policy titled, "Infection Control: interim policy addressing healthcare crisis related to Human Corona virus", dated 3/5/20, was provided by the Infection Prevention Nurse at 12:10 p.m. The policy indicated, "...for a resident on Contact precautions: staff don gloves and isolation gown before contact with the resident and/or his/her environment..." Interview with RN 1, at 9:45 a.m., indicated it wasn't necessary to don gown and gloves if she was just talking to the resident and not providing care. Interview with CNA 1, at 9:50 a.m., indicated she was not aware the resident was on TBP. She had not noticed the signs on the door or the isolation cart next to the door. Interview with the Director of Nursing, on 5/28/21 at 12:55 p.m., indicated staff entering a TBP room were expected to have a face shield, mask, gown and gloves on.		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Staff identified practicing this deficient practice were immediately in serviced on the policy for infection control. **2) How the facility identified other residents:** All residents in transmission-based precautions	

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	Interview with the Infection Prevention Nurse, on 5/28/21 at 10:40 a.m., indicated they did not have a shortage of PPE, they were very well stocked at that time. 3.1-18(a)		have the potential to be affected by this deficient practice. **3) Measures put into place/ System changes:** Facility IDT team completed a root cause analysis and Infection Control Self-Assessment with the Corporate Infection Control Preventionist. Reviewed findings and developed action plan and education materials based on findings. Staff will be re-educated regarding PPE use and spread of infections as it relates to transmission-based precautions. **4) How the corrective actions will be monitored:** The Director of Nursing or designee will monitor for appropriate PPE use by completing visual rounds throughout the facility at least once daily to ensure that staff and visitors are practicing appropriate	

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			Infection Control guidelines. Daily monitoring and visual rounds will continue for at least 6 weeks and until compliance in maintained then rounds and monitoring 5x/week for 5 weeks x2 weeks, then at least 3x/week thereafter on varied shifts. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 06/14/2021**	