STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 00 B. WING	11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00364701, IN00365272, IN00365352, IN00366871, and IN00367397. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00364701 - Unsubstantiated due to lack of evidence. Complaint IN00365272 - Unsubstantiated due to lack of evidence. Complaint IN00365352 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00366871 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00367397 - Unsubstantiated due to lack of evidence. Survey dates: November 29 and 30, 2021 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 15 Medicaid: 63 Other: 8 Total: 86	F 0000		

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 determined that other safegaurds 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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/1/21.			
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 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			

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	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 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	F 0880	**F880 Infection Prevention and Control** The facility request	12/14/2021

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	implemented, including those to prevent and/or contain COVID-19, related to hand hygiene not completed before and after using gloves, the disposal of a used lancet into the garbage can, not monitoring for COVID-19 signs and symptoms, and not obtaining an prn (as needed) order for COVID-19 testing for 1 of 1 glucometer observations and for 1 of 3 residents reviewed for COVID-19. (Residents J and E) Findings include: 1. During an observation of a glucometer testing for blood sugar level on 11/30/21 at 9:30 a.m., QMA 1 was observed standing at the medication cart. At that time, the QMA gathered the glucometer, a test strip, a lancet and alcohol wipes and entered Resident J's room. She placed the glucometer and supplies on the over bed table and walked over to the box of gloves on the wall. She donned a clean pair of gloves to both hands, however, she did not perform hand hygiene. She wiped the resident's finger with an alcohol wipe and let it dry. She took the lancet and pricked the resident's middle finger and placed the blood on the strip that was in the glucometer machine. She threw the used lancet, gloves and strip into the garbage can and left the room. She walked over to the medication cart placed the glucometer into the medication drawer without cleaning it first. She opened up her computer, touched the mouse and documented the blood sugar result for the resident. The QMA did not perform hand hygiene after glove removal. There was a wall mounted hand sanitizer unit outside of the resident's room. Interview with the QMA at that time, indicated the lancet was supposed to be disposed of in the sharps container. It was only her third day of		paper compliance for this citation *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/staff identified:** QMA 1 was re-educated on Infection control policy. Competency with return demonstration was given on proper use of Glucometer, hand hygiene and disposal of lancet, related to properly prevent and/or contain Covid-19. Physician order for resident (E) was obtained and followed for Covid-19 monitoring and as needed (PRN) Covid-19 testing, related to properly prevent and/or contain Covid-19.	

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	work and no one had taught her how to clean the glucometer after each use. She indicated she did not perform hand hygiene before donning and after doffing her gloves. Interview with the Nurse Consultant at the time of the observation indicated the glucometer should be cleaned after every use. Interview with the Director of Nursing on 11/30/21 at 1:15 p.m., indicated the QMA was new, however, hand hygiene was to be done before and after using gloves and the lancet should have been disposed into the sharps container. 2. The record for Resident E was reviewed on 11/30/21 at 10:49 a.m. Diagnoses included, but were not limited to, Extended Spectrum Beta Lactamase (ESBL - enzyme indicating bacterial infection) resistance in her urine, diabetes, stroke, hypertension, atrial fibrillation, and coronary artery disease. The resident was admitted to the facility on 10/8/21. The Significant Change Minimum Data Set (MDS) assessment, dated 11/4/21, indicated the resident was cognitively impaired for daily decision making. The resident was admitted to the hospital on 11/22/21. Upon readmission to the facility on 11/27/21, the Physician's Orders lacked an order for COVID-19 monitoring and as needed (prn) COVID-19 testing. The November 2021 Medication Administration Record (MAR), indicated no COVID-19 monitoring was completed on the following dates: 11/27/21, 11/28/21, and 11/29/21. Interview with LPN 1 on 11/30/21 at 11:23 a.m.,		**2) How the facility identified other residents:** All residents requiring blood glucose monitoring have the potential to be affected by the alleged deficiency. All residents admitted and/or readmitted to the facility have the potential to be affected by the alleged deficiency. Audit was completed of all new admissions and readmission over the last 30 days to ensure Covid-19 monitoring and testing orders were in place. **3) Measures put into place/ System changes** Staff will be re-educated regarding infection control guidelines, proper hand hygiene, proper use of glucometer, and Physician Orders for Covid-19 monitoring and testing for new and readmitted residents.	

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	indicated the resident should have been assessed and monitored for COVID-19 symptoms after readmission to the facility. The LPN also indicated the resident should have had a Physician's order for prn COVID-19 testing. 3.1-18(b)		**4) How the corrective actions will be monitored:** The Director of Nursing or designee will complete care rounds on at least 5 staff members per week at varied times/shifts to ensure proper infection control techniques are followed. Director of Nursing or Designee will complete audits on new admission and readmission 5 days per week and as needed to ensure Covid-19 monitoring and testing are present. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive 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:** 12/14/2021	
F 0886 SS=D	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff			

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Bldg. 00	§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 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			

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	(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 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 2 of 3 staff records reviewed. (CNA 1 and the Activity Director) Finding includes: The employee COVID-19 testing records for the past 9 weeks were reviewed on 11/30/21 at 12:45 p.m. CNA 1, an unvaccinated employee, was tested for COVID-19 on 10/6, 10/13, 10/20, 10/27, 11/3,	F 0886	**F886 Covid-19 Testing-Residents & Staff** The facility request paper compliance for this citation *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*	12/14/2021

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	11/10, 11/17, and 11/24/21. The testing results indicated the employee was only tested one time a week. The Activity Director, an unvaccinated employee, was tested for COVID-19 on 10/6, 10/13, 10/20, 10/27, 11/3, 11/10, 11/17, and 11/24/21. The testing results indicated the employee was only tested one time a week. Interview with the Director of Nursing (DON) on 11/30/21 at 1:50 p.m., indicated she was testing according to the county positivity rate and not the transmission rate. Interview with the Administrator on 11/30/21 at 2:00 p.m., indicated she was unaware the guidance for testing had changed for employee testing for COVID-19. The Indiana Department of Health document, "Long-term Care COVID-19 Clinical Guidance", updated 11/22/21, Level of COVID-19 community transmission Minimum Testing Frequency of Unvaccinated Staff: Low (blue) Not recommended Moderate (yellow) Once a week Substantial (orange) Twice a week High (red) Twice a week "The facility should test all unvaccinated staff at the frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past week. Facilities should monitor its level of community transmission every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table above.		*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/staff identified:** Administrator and DON educated by State Surveyor regarding The Indiana Department of Health Documents "Long-term care Covid-19 Clinical Guidance" related to Level of COVID-19 community transmission Minimum Testing Frequency of Unvaccinated Staff Guidelines. Facility implemented testing frequency based on the community transmission rate level. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficiency. **3) Measures put into place/ System changes**	

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	· If the level of community transmission increases to a higher level of activity, the facility should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity level are met. · If the level of community transmission decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the level of community transmission has remained at the lower activity level for at least two weeks before reducing testing frequency." According the CDC COVID data tracker, the local county transmission rate had been high 10/1-11/23/21. 3.1-18(b)		Staff will be re-educated regarding minimum testing frequency guidelines. Administrator or designee will complete a weekly audit to ensure all unvaccinated staff are in compliance with the guidelines. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive 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:** 12/14/2021	