STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155740	A. BUILDING 00 B. WING	01/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. This visit included a Residential COVID-19 Quality Assurance Walk Through. Survey dates: January 14, 2022. Facility number: 000448 Provider number: 155740 AIM number: 100275140 Census Bed Type: SNF/NF: 39 Residential: 88 Total: 127 Census Payor Type: Medicaid: 20 Other: 19 Total: 39 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 21, 2022.	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.			

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

Any deficiencystatement 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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	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 facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

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	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 and interview, the facility failed to properly prevent and/or contain COVID-19 by staff not wearing face masks appropriately in the Crestwood Unit and in a TBP (Transmissioned Based Precaution) room on the 300 hall, staff not cleaning eye protection appropriately and not performing hand hygiene after touching PPE (Personal Protective Equipment) during random observations. Findings include: On 1/14/22 at 9:34 a.m., Activity Aide 33 was observed reading to six residents in the common area, across from the nurses station, on the Crestwood Unit. Her mask was pulled down and exposed her nose and mouth. On 1/14/22 at 11:29 a.m., CNA 13 wore a surgical mask and applied an N95 mask over the	F 0880	Preparation or execution of his plan does not constitute admission nor agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. DON immediately in-serviced CNA 13 on proper masking; CNA 17 on proper cleaning of protective eye wear including hand hygiene protocol; Activity Aide 33 on masking at all times, and Laundry Aide 21 on properly wearing N95.	02/05/2022

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	surgical mask to enter a room on the 300 hall that had signage on the door to indicate the resident was in TBP. During an interview, with the IP (Infection Prevention) nurse with the DON present, on 1/14/22 at 11:50 a.m., he indicated staff should not be applying an N95 over a surgical mask. On 1/14/22 at 12:58 p.m., CNA 17 was standing in the common area on the 300 hall, as she talked to a resident, she used her shirt to wipe off her goggles and then placed them on her face. She asked the resident if she was ready, without performing hand hygiene, she assisted the resident as she held onto her gait belt and walked her down the hall to her room. During an interview with CNA 13, on 1/14/22 at 1:00 p.m., she indicated she normally took off her surgical mask and applied an N95. During an interview with CNA 17, on 1/14/22 at 1:02 p.m., she indicated she would not normally wipe her goggles on her shirt, she was just trying to see and would normally perform hand hygiene after touching her goggles. On 1/14/22 at 1:09 p.m., Laundry Aide 21, applied an N95 over her surgical mask to enter a room on the 300 hall that had signage on the door to indicate the resident was in TBP. During an interview, with the Activity Director, on 1/14/22 at 1:20 p.m., she indicated she would not normally pull her mask down when she talked with the residents. One of the residents indicated they could not hear her and asked her to pull her mask down, it was something she would not normally do and it was a real quick thing.		The facility has determined that all residents have the potential to be affected. A root cause analysis of the identified deficiencies was conducted, as was a review of the most recent Infection Control Assessment dated 11/09/2021. Policies were reviewed and revised as needed; communication tools regarding the appropriate type of PPE and donning and doffing guidance were reviewed and distributed to staff and within the facility. Based on the root cause analysis, all staff was in-serviced on proper hand hygiene, and on how and when to don and doff PPE with return demonstrations and understand when to perform hand hygiene. All staff was re-educated on the need to maintain face covering over the mouth and nose as well as use of appropriate covering. Staff received training on the cleaning and reusable PPE according to CDC guidelines. Daily random observations executed by DON, IP, and/or designee, of personnel adhering to proper COVID-19 infection control measures. The daily monitoring includes but is not limited to hand hygiene, donning and doffing technique, protective eye wear, respirator devices, mask use. Findings are reviewed with all personnel observed. Corrective action provided as	

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	Signage titled "Current PPE Requirements," dated 1/13/22 and provided by the Administrator, on 1/14/22 at 2:39 p.m., indicated the following: "Green zones, Face masks: surgical grade or better. Eye protection: Goggles or Face Shields for all interactions within 6 feet of an individual. Yellow and Red Zones: Follow PPE instructions posted on resident door." A 7/7/21 revised policy titled, "20210707 FOR STAFF WORKING IN DESIGNATED CARE UNITS GREEN, YELLOW AND RED ZONES," provided by the Administrator, on 1/14/22 at 2:39 p.m., indicated the following: "Procedure: ... Green Zone: 1. Standard Based Precautions. 2. PPE required: Universal surgical mask issued by Timbercrest (unless instructed to wear KN95 by DON/Infection Preventionist/HR). Staff who have received both doses of the COVID vaccine and have submitted proof thereof are permitted to wear surgical grade facemasks issued by Timbercrest... Yellow zone 2. PPE required: Approved KN95 Mask or KN95 covered with cloth facemask (may be used for entire shift unless were or visibly soiled). Staff who have received both doses of the COVID vaccine and have submitted proof thereof are permitted to wear surgical grade facemasks issued by Timbercrest...." 3.1-18(b)(1)		need. Monitoring for compliance will include, the Director of Nursing, the Infection Preventionist, or designee, will completing daily random Validation Checklists of personnel performing hand hygiene, proper use of PPE and donning/doffing procedures. To ensure staff are complying with our facility's protocol, this random monitoring will occur daily for six (6) weeks, then weekly x 18. The Director of Nursing, the Infection Preventionist, or designee, will complete daily rounding throughout the facility to ensure that PPE is distributed and readily available were needed and signage is up to date. To ensure staff are complying with our facility's protocol, this random monitoring will occur daily for six (6) weeks, then weekly x 18. Results of the audits will be discussed monthly with the QAPI committee and summary report provided to the QAA committee until such time it is determined that substantial compliance is maintained	
R 0000 Bldg. 00	This visit was for a Residential COVID-19 Quality Assurance Walk Through. This visit included a Nursing Home COVID-19 Focused Infection Control Survey.	R 0000		

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	Survey dates: January 14, 2022. Facility number: 000448 Residential Census: 88 Timbercrest Church of the Brethren Home was found to be in compliance with 410 IAC 16.2-5 in regard to the COVID-19 Quality Assurance Walk Through. Quality review completed on January 21, 2022.			