STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155176	A. BUILDING 00 B. WING	07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLENBROOK REHABILITATION & SKILLED NURSING CENTER	3811 PARNELL AVE FORT WAYNE, IN 46805

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00357017. Complaint IN00357017 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: July 28, 2021 Facility number: 000092 Provider number: 155176 AIM number: 100266090 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicare: 4 Medicaid: 40 Other: 3 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 2, 2021	F 0000	**The creation and submission of this 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 of regulation.** **Due to the scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after August 27, 2021.** **Glenbrook Rehabilitation and Skilled Nursing Center is requesting paper IDR review**	
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			

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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	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 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.			

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	(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 observations, interviews and record reviews, the facility failed to ensure staff used Personal Protective Equipment for prevention of the transmission of COVID-19 for 1 of 1 observations. (Employee 2) Findings include: During an observation on 7/28/21 at 1:00 P.M., Employee 2 was observed standing beside the medication cart at the 200 hall nurses' station with her mask down below her chin. A resident was talking to her. The resident was standing within 6 feet of the nurse. During interview at the same time, Employee 2 indicated there was not a reason for the mask being below her chin and that it	F 0880	Based on observation and interview, the facility failed to ensure staff followed the appropriate mask wearing procedure during 1:1 staff observation. **F880** **What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice:** · No residents were found to have affected by the deficient practice · Staff member who was found to be non-compliant was educated	08/27/2021

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	should not be worn under her chin. During an interview on 7/28/21 at 1:50 P.M., the Administrator indicated the facility did not have a specific PPE policy because it was mixed in with other infection control policies. The document provided by the Administrator on 7/28/21 at 2:30 P.M., was titled "Sequence for Putting on Personal Protective Equipment (PPE)," and indicated "2. Mask or Respirator Secure ties or elastic bands at middle of head and neck Fit flexible band to nose bridge Fit snug to face and below chin ...." 3.1-18(a)		regarding appropriate mask usage and will enter the progressive discipline process **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · The Infection Preventionist (IP) or designee will educate all staff regarding appropriate mask usage before August 27, 2021. · The IP will provide education and training to the Interdisciplinary Team, staff and residents regarding any updates or changes to the PPE requirements as directed by the ISDH and ASC guidelines as the occur. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · A root cause analysis was conducted by the Infection Preventionist, with input from the facility Medical Director/NP/ED/DNS to identify the root cause and develop solutions/systemic changes to address the root cause · The IP will provide education and training to the IDT and all staff any updates or changes to the PPE requirements as directed by the ISDH and ASC guidelines as	

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			they occur. · Education will be provided to the IDT including in-service material, observation, and QA tools · The facility LTC Infection Control Self-Assessment will be reviewed with the consultant IP to determine accuracy · Daily observational rounds will be conducted 5 days a week for 6 weeks until compliance is maintained by the IP/designee using the PPE Observation Tool (Attachment A) to observe for appropriate mask utilization (mask over both chin and nose and straps secured as designed). · The IP/CEN will provide ongoing training, oversight, resources, and competencies as needed based on the Observation Rounds Audit and QA tools identifying ongoing areas of concern or not meeting threshold. **How the corrective actions (s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:** · The IP/Designee will monitor each solution and systemic change identified in RCA daily or more often as necessary for 6 weeks and until compliance is maintained. · The IP/designee will complete Daily Observational/ Visual rounds throughout the facility 5 days a week to ensure	

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			staff are practicing appropriate Infection Control Practices and complying with the solutions identified in the RCA. · PPE Observation Tool will be completed daily, 5 times per week by IP/designee for 6 weeks and until 100% compliance is maintained for 6 months · The IP will report the analyzed data and any changes or addition to the DPOC at the monthly QAPI meeting · If a threshold of 100% is not achieved, an action plan will be developed to ensure compliance. · The facility will review, update, and make changes to the DPOC as needed with input and oversight from the Infection Preventionist for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit **By what date the systemic changes will be completed:** Completion Date: August 27, 2021	