STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 Investigation of Complaint IN00360420. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00360420 - Unsubstantiated due to lack of evidence. Survey dates: August 27 and 30, 2021 Facility number: 000103 Provider number: 155196 AIM number: 100290000 Census Bed Type: SNF/NF: 60 SNF: 18 Residential: 41 Total: 119 Census Payor Type: Medicare: 11 Medicaid: 45 Other: 22 Total: 78 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on September 02, 2021.	F 0000	The directed plan of correction (DPOC) is to serve as Altenheim's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. **The facility respectfully requests desk review for the following citation.**	
F 0880 SS=E 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			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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, interview, and record review, the facility failed to implement infection control measures to prevent the spread of COVID-19. Staff failed to wear the correct personal protective equipment (PPE) and complete hand hygiene for 4 of 14 residents who resided in a yellow zone reviewed for IC (infection control). (Residents D, E, F, and G) Findings include: On 8/30/21 from 11:45 a.m. to 11:55 p.m., observed a NP (Nurse Practitioner) to enter Resident F's yellow zone room without gowning, gloving, and putting on a face shield prior to entering the room.	F 0880	**F880 Infection Prevention and Control** **S/S D** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** There were no residents harmed by the alleged practice. The staff members, visitors, and medical providers found to have deficient practices were immediately educated on proper donning,	09/17/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The NP was observed to not use hand sanitizer or perform hand hygiene after exiting Resident F's room. On 8/30/21 from 12:00 p.m. to 12:25 p.m., CNA 1 (Certified Nursing Assistant) 1 was observed passing lunch trays to residents who resided in the yellow zone. CNA 1 entered Resident D's room without hand sanitizing, gowning, and gloving before bringing Resident D's lunch into their room. Upon exiting, CNA 1 was observed to not use hand sanitizer or perform hand hygiene prior to pushing the lunch cart to the next resident's room. CNA 1 next entered Resident E's room without gowning or gloving. CNA 1 was observed to bring Resident E's lunch back out of the room and place it back on the food cart. CNA 1 then proceeded to pick up a sheet, at the door of Resident E's room, and took it to the soiled utility room. CNA 1 was observed to not change gloves and perform hand hygiene. When CNA 1 came back down hall to continue passing trays at 12:30 p.m., and was interviewed. During the interview CNA 1 indicated she should have gowned and gloved prior to going into rooms as well as using hand sanitizer between each room. On 8/30/21 at 12:35 p.m., Observed 3 family members walk into Resident G's room without hand sanitizing, gowning, and gloving. Interview with QMA 1, on 8/30/21 at 12:40 p.m., indicated Resident G's family members were there on a compassionate care visit and they should have put on gowns and gloves before entering Resident G's room. QMA 1 (Qualified Medication Assistant) was observed to gown up and pull out three (3) gowns from the PPE cart and took them into Resident D's room. On 8/30/21 at 12:50 p.m., 2 of the 3 family members		doffing, and utilization of PPE and hand hygiene requirements. **II. The facility will identify other residents that may potentially be affected by practice.** Other residents in contact and droplet isolation have the potential to be affected by the alleged deficient practice. Rounds were made to ensure all staff and visitors (including medical providers) were donning and doffing PPE as they entered and exited resident rooms who have been placed in transmission-based precautions as well as performing hand hygiene appropriately. **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** · CMS-CDC Fundamentals of Covid-19 Prevention Training Self-Assessment Questionnaire completed indicating need for "Hand Hygiene and PPE Training" which was implemented for facility staff. (Attachment A) · Root Cause Analysis (RCA) with facility consultant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	from Resident G's room were observed standing next to QMA 1's medication cart with 1 of the 2 family members still wearing their protective gown, without being asked by QMA 1 to remove it Review of facility's bedboard, on 8/30/21 at 12:50 p.m., indicated the isolation yellow zone had a census of 14 residents, which included Residents D, E, F, and G. On 8/30/21 at 3:30 p.m., the DON (Director of Nursing) provided the Infection Prevention and Control Program policy, dated June 6, 2019, and indicated the policy was the one currently being used by the facility. A review of the policy indicated important facets of infection prevention, included, but not limited to: educating staff and ensuring that they adhere to proper techniques and procedures and following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). On 8/31/21, at 8:00 a.m., a review of the facility's COVID-19 tool kit, dated 3/9/21, indicated Unknown COVID-19 status (Yellow). that all residents in this category warrant transmission-based precautions (droplet and contact) HCP (health care providers) will wear single gown per resident, gloves, N95 mask and eye protection (face shield/or goggles). 3.1-18(b)		Infection Preventionist, including input from the facility Medical Director/DON/IP was completed (Attachment B) · Consultant Infection Preventionist educated IDT/Leadership team on the Indiana State Department of Health COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, PPE utilization including donning and doffing, and how and when to perform hand hygiene utilizing CDC and WHO guidelines (Attachment C) · All staff and medical providers were educated regarding PPE donning and doffing, and how and when to perform hand hygiene with return demonstrations. All staff also educated that they should ensure visitors are using PPE and performing hand hygiene appropriately. (Attachment D) **IV.** The facility LTC Infection Control Self-assessment was reviewed with the consulting Infection Preventionist resulting in an updated LTC Infection Control assessment being completed with input from the Consultant IP/Medical Director and DON (Attachment E) **V. The facility will monitor the corrective action**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			by implementing the following measures. · The IP/DON or designee will observe to ensure staff and visitors (including medical providers) are properly donning/doffing PPE as they enter and exit resident rooms who are in transmission-based precautions daily for 6 weeks, then weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring using the Quality Improvement Tool F-880 audit. (Attachment F) · The IP/DON or designee will observe staff and visitors (including medical providers) to ensure proper hand hygiene practices (when and how) are performed daily for 6 weeks then weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring using the Quality Improvement Tool F-880 audit. (Attachment G) The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			compliance is below 100%. **VI. Plan of correction completion date.** Date of compliance: 9/17/2021 The Administrator will be responsible for ensuring the facility is complying by date of compliance listed. The plan of correction is to serve as Altenheim's credible allegation of compliance.	