STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	09/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(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 the Investigation of Complaints IN00327428 and IN00331695. This visit included a Covid-19 Focused Infection Control Survey. This visit also included a Residential Covid-19 Quality Assurance Walk Through Survey. Complaint IN00327428- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00331695- Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited at F880. Survey dates: September 28 & 29, 2020 Facility number: 000191 Provider number: 155294 Census Bed Type: SNF: 29 Residential: 24 Total: 53 Census Payor Type: Medicare: 10 Other: 19 Total: 29 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 6, 2020.	F 0000		

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

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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 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;			

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	(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, interview and record review, the facility failed to ensure staff followed the infection control policy and procedures and failed to perform hand hygiene in accordance with facility policy potentially affecting 15 of 15 residents residing on 1 of 2 healthcare hallways (500 hallway).	F 0880	**F 880 INFECTION PREVENTION AND CONTROL** **1.What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?** ·Residents in rooms 502 and	10/28/2020

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	Findings include: 1. On 09/28/20 at 1:05 p.m., CNA 13 was observed passing ice in the 500 hallway. CNA 13 was wearing a K95 face mask and went into Room 502, an isolation room, without donning proper PPE to get the resident's disposable lunch container. CNA 13 walked out of the resident's room, down the hall, to the Tea Room (dining room) on the 500 hallway, to place the container in the refrigerator. CNA 13 did not wear a gown or gloves while in the resident's room and did not wash her hands after handling the resident's food container. 2. On 09/28/20 at 3:27 p.m., CNA 14 was observed assisting a resident, in Room 503, to stand from her wheelchair so her pants could be pulled up. The CNA 14's back was to the surveyor and the resident's door was open. CNA 14 did not wash his hands. During an interview, on 09/28/20 at 3:30 p.m., CNA 14 indicated he did not wash his hands after taking care of the resident in Room 503. CNA 14 returned to the resident's room to wash his hands in the bathroom sink. The resident requested some fresh ice water so CNA 14 returned with a cup of ice water. After leaving her room, he did not clean his hands. He indicated he had an in-service on night shift for handwashing. He asked if he should wear gloves before passing ice. A current facility policy, titled "Hand Washing," provided by the interim Executive Director on 09/29/20 at 9:30 a.m., indicated "...Hand washing is performed:...c. Before and after each resident contact...assisting others with toileting...handling food...."		503 were monitored by nursing for increased signs and symptoms related to potential infection; such as temperature, respirations, and oxygen saturation due to identified team members not following established PPE and/or handwashing policies. **1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** ·All facility residents who are on the facility healthcare unit have the potential to be affected by the alleged deficient practice. All residents were monitored for signs and symptoms of potential infection by the nursing staff; including temperature, respirations, and oxygen saturation · All Staff have been re-educated on PPE usage by nurse management and QSource IP consultant with emphasis on residents in insolation by 10/28/2020 or prior to returning to work ·All staff have been re-educated on proper handwashing by nurse management and QSource IP consultant by 10/28/2020 or prior to returning to work. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?**	

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	A current facility policy, titled "Coronavirus (COVID-19) Droplet Precautions," provided by the interim Executive Director on 09/29/20 at 9:30 a.m., indicated "...Persons Under Investigation for COVID-19...2. Place resident in a private room and close the door...5. Wear gloves and wash hands before and after donning gloves...7. Remove the gloves before leaving the room...9. Wear a clean gown when entering the room...14. Use disposable dinner ware and dispose of in the resident's room...." 3.1-18(a) 3.1-18(l)		·All Staff have been re-educated by nurse management and QSource IP consultant and completed a competency tool with return demonstration on PPE usage by unit by 10/28/2020 or prior to returning to work ·All staff have been re-educated and completed a competency tool with return demonstration on proper handwashing by 10/28/2020 or prior to returning to work ·The Facility has engaged Q-source for a Quality Improvement Plan related to Infection Prevention and Control to identify and monitor the facility for areas of opportunity in infection control. ·An RCA will be conducted with the consultant IP to establish the systematic failure on behalf of the facility ·Solutions and systematic changes will be developed and implemented with the consultant IP ·Consultant IP and facility will review the LTC infection control self-assessment to determine if changes need to be made **1.How corrective actions will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ·Compliance audit provided by QSource will be completed by	

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			appointed department heads weekly x 8 weeks and monthly thereafter. Audits will be completed daily five days a week X4 weeks, Weekly X4 weeks and monthly thereafter. ·Daily walking rounds will be completed by IDT team members: ED, Administrator, DON, ADON, and MDS to look for signs of noncompliance. ·Results of audit tool will be presented to Administrator weekly for eight weeks. Compliance and any evidence of trends will be discussed monthly with the QAPI Committee, including MD and ED to review for follow-up. Identified noncompliance may result in staff reeducation and/or disciplinary action.	
R 0000 Bldg. 00	This visit was for a Residential COVID-19 Quality Assurance Walk Through. This visit included a Nursing Home COVID-19 Infection Control Survey. This visit also included the Investigation of Nursing Home Complaints IN00327428 and IN00331695. Survey dates: September 28 & 29, 2020 Facility number: 000191 Residential Census: 24 Forum at the Crossing was found to be in compliance with 410 IAC 16.2-5 in regard to the	R 0000		

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	Residential COVID-19 Quality Assurance Walk Through. Quality review was completed on October 6, 2020.			