DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155242	A. BUILDING 00 B. WING	03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00348231. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00348231 - Substantiated. Federal/state deficiency related to the allegation is cited at F880. Survey dates: March 17 and 18, 2021. Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 117 Total: 117 Census Payor Type: Medicare: 10 Medicaid: 84 Other: 23 Total: 117 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1 Quality review completed on March 23, 2021.	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			

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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	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 observation, interview and record review, the facility failed to ensure staff were wearing a face mask properly, failed to perform hand hygiene and failed to wear the proper Personal Protective Equipment (PPE) in a resident room with droplet precautions for 3 of 7 random observations. (Resident G, H and J) Findings include: 1. During a observation and interview on 3/18/21 at 10:54 a.m., CNA 1 walked into Resident H's room with only a surgical mask on and no hand hygiene was performed upon entering. The door had signage in place, indicating droplet precautions. CNA 1 was asked if she should have	F 0880	We respectfully request desk review as a follow up for this plan of correction. Any additional documents, in-service education and audit tools can be made available for your review upon request. 1) what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. Residents G,H and J were monitored and not affected by this alleged deficient practice. CNA #1 was educated	04/07/2021

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	additional PPE on and she said she was not putting on a gown that someone else wore. She had goggles in her pocket. She exited the room and walked to room 711 and took an isolation grown off the door and donned without hand hygiene. She did not don gloves, N95 or goggles prior to entering the room. a.The clinical record for Resident H was reviewed on 3/18/21 at 1:28 p.m. Diagnoses included, but were not limited to, pneumonia, sepsis, heart failure and fibromyalgia. Resident H was admitted to the facility on 3/12/21. The clinical record lacked an order for droplet precautions or a health care plan for isolation. 2. During an observation on 3/18/21 at 11:59 a.m., CNA 2 was observed pushing Resident J down the hall. The resident did not have a face mask on. She proceeded to take the resident to her room and pushed the wheelchair into the room from the hall. The door had signage in place, indicating droplet precautions. She then donned a gown without hand hygiene or gloves. At 11:01 a.m., she removed her gown, hung it up inside the door and use Antibacterial Hand Rub (ABHR) when she exited. a.. The clinical record for Resident J was reviewed on 3/18/21 at 1:35 p.m. Diagnoses included, but were not limited to, fracture of left calcaneus, pain, muscle weakness and difficulty walking. Resident J was admitted to the facility on 2/26/21.		immediately and her employer (nurse agency) notified of her non compliance with policy. CNA and agency notified that she is no longer to return to facility for employment. CNA#2 was educated immediately with return demonstration and acknowledges understanding. 2) 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. A root cause analysis was performed related to infection control deficiencies identified. See diagrams for findings of root cause analysis. The findings of the root cause analysis leading to these alleged deficient practices were reviewed. All staff will be inserviced by 4-7-21 per DON/designee on hand washing, donning/doffing of masks and gowns. See Attachments A-C. Skills validation to be completed by 4-7-21 per DON/designee on hand washing and donning/doffing of masks and gowns with return demonstration. Monitoring will be completed daily with infection control rounds as well as visual rounds throughout the facility being conducted to ensure staff are practicing appropriate infection control practices as they relate to appropriate ppe usage and hand	

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	A health care plan, dated 3/9/21, indicated the resident was at risk for active infection related to potential exposure to Covid-19. Interventions included, but were not limited to, maintain appropriate PPE use according to state requirements. 3. During an observation on 3/18/21 at 11:11 a.m., CNA 2 removed an isolation gown from across the hall and entered Resident G's room prior to donning or hand hygiene. The door had signage in place, indicating droplet precautions. On 3/18/21 at 11:26 a.m., Unit Manager 3 indicated she was not aware there was an aide entering isolation rooms with only a surgical mask on. She indicated the aide should have received an N95 mask when she was screened in prior to work. During an interview and observation on 3/18/21 at 11:36 a.m., CNA 2 indicated she was wearing a surgical mask under her N95 mask. The N95 mask did not have any ear and/or head loops, but was being held over her nose and mouth by her prescription glasses and goggles. CNA 2 indicated all the straps broke off. a. The clinical record for Resident G was reviewed on 3/18/21 at 1:20 p.m. Diagnoses included, but were not limited to, cerebral infarction, dysphagia, acute kidney disease, hemiplegia and hemiparesis. Resident G was admitted to the facility on 2/25/21. A health care plan, dated 3/9/21, indicated the resident was at risk for active infection related to potential exposure to Covid-19. Interventions		washing hygiene. These rounds will occur 7 days a week for 6 weeks , then 5 times a week for 6 weeks, then weekly for 6 months. monitoring tool - see attachment D. 3) what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff to be inserviced by 4-7-21 per DON/designee on proper hand washing and donning/doffing of masks and gowns with return demonstration. Ad Hoc QAPI meeting conducted on 4-2-21 and attended by Administrator, DON, IP nurse, Medical Director, SDC , ADON. Root cause analysis reviewed and steps to gain compliance discussed and it was identified that staff did not complete return demonstration of ppe donning/doffing and handwashing technique in previous education. See Attachments A-C. It was identified that staff need re-educated and monitored for compliance more frequently. Monitoring will ber conducted daily with infection control rounds as well as visual rounds throughout the facility being conducted to ensure compliance. These rounds will occur 7 days a week for 6 weeks, then 5 times a week for 6 weeks, then weekly for 6 months. Staff education will be completed with return demonstration. Audits will be	

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	included, but were not limited to, maintain appropriate PPE use according to state requirements. On 3/18/21 at 3:04 p.m., the DON indicated Resident G and J were both out of isolation, but they did not have a current bed for them. Staff should still be following the isolation precautions because they resided on the yellow zone. A facility-wide inservice on donning, doffing, PPE and Covid-19 infection control was completed on 1/18/21. CNA 1 and CNA 2 were in attendance and signed the inservice form. Review of a current facility policy, dated 3/11/21, titled "Novel Coronavirus (COVID-19)," provided by the DON on 3/18/21 at 10:08 a.m., indicated the following: "PURPOSE To provide guidance on the novel Coronavirus (COVID-19) to help facilities protect, to the extent possible, the health, safety, and well-being of all residents and stakeholders. ...SUSPECTED CASE OF COVID-19 If this occurs, a facility should: ...4. Place the resident in...maintained in accordance with current guidelines.... a. Place resident in a private room.... b. Place resident in droplet precautions.... 5. Require any person entering resident's room to wear a gown, gloves, mask (respirator) and eye protection.... ...8. If possible.... a. For resident admitted to a facility and are not fully vaccinated i. Resident/patient placed in droplet precautions for 14 days."		conducted and presented to the QAPI committee to review to ensure compliance is being met. See Attachment D. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: DON/designee will audit/conduct rounds daily 7 days a week for 6 weeks, then 5 times a week for 6 weeks , then weekly for 6 months. Ongoing compliance with this corrective action will be monitored via the facility QAPI program, with meetings being held monthly, and is overseen by the CEO/Administrator. F-880 audit tools which are a part of the plan of correction submitted will be completed. If the threshold of 100% is not met then an action plan will be developed via the QAPI committee to ensure compliance and audits will continue and be monitored monthly and as needed ad hoc until compliance is achieved. 5) by what date the systemic changes for each deficiency will be completed; April 7,2021.	

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	This federal tag relates to Complaint IN00348231. 3.1-18(b) 3.1-18(l)			