STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING 00 B. WING	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

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F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00363940. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00363940 - Substantiated. Federal/State deficiencies related to the allegations are cited at F0880 and F0886. Survey dates: October 5, 2021. Facility number: 000099 Provider number: 155188 AIM number: 100291140 Census Bed Type: SNF/NF: 110 Total: 110 Census Payor Type: Medicare: 6 Medicaid: 84 Other: 20 Total: 110 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 5, 2021	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00363940) with a COVID-19 Focused Infection Control Survey on 10/5/2021. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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

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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 properly prevent and/or contain COVID-19 for 1 of 4 residents reviewed for infection control (Resident G). Findings include: The clinical record for Resident G was reviewed on 10/5/21 at 1:47 p.m. The Resident's diagnosis included, but were not limited to, diabetes and hypertension. A physician's order, dated 9/29/21, indicated she was to be in droplet precautions.	F 0880	**F 880** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Hospice Chaplin 4 was educated on residents who are in TBP: signage on each door is posted with PPE requirements. Hospice Chaplin instructed before visiting with any resident, he must check with nurse first. In addition, the company that the Hospice Chaplin works for was contacted and educated on the above.	10/18/2021

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	On 10/5/21 at 1:47 p.m., Resident G's room was randomly observed. There was a sign posted outside of the door instructing that she was in Contact Droplet TBP (Transmission Based Precautions) and a N95 mask, Universal Eyewear, Gown and Gloves were required to be used when entering the room. Hospice Chaplin 4 was standing at the foot of her bed. He was wearing a surgical mask and a face shield. He did not have on a N95 mask, gown, or gloves. He touched the foot of her bed and was speaking to her. He then exited the room and performed hand hygiene. During an interview on 1:47 p.m., Hospice Chaplin 4 indicated he was unaware that she was in Contact Droplet TBP and that he had not noticed the sign prior to entering the room. He had not been educated that she was in TBP prior to visiting her and had just been instructed to wear a face shield while in the patient care areas. During an interview on 10/5/21 at 1:52 p.m., Unit Manager 6 indicated Hospice Chaplin 4 should have worn full PPE (Personal Protective Equipment) when entering her room. On 10/5/21 at 2:50 p.m., the DON (Director of Nursing) provided the Standard Precautions and Transmission Based Precautions Policy, reviewed 6/25/21, which read "...Transmission-Based Precautions is the second tier of precautions and are for resident's known or suspected to be infected by epidemiologically important pathogens spread by airborne or droplet transmission or by contact with the dry skin or contaminated surfaces...2. Tier 2 Precautions Droplet Precautions...b. Staff will utilize the proper PPE's [sic] upon entering the room or cubical area..."		**Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. The DON or designee will complete the following: - Staff involved will be educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. Follow CDC and facility policy. - Staff educated that visitors will continue to be screened at the front desk. They will be provided with a faceshield and mask and instructed to proceed to the designated nurses station for further guidance. The staff member at the nurses station will then direct the visitor to the resident room and provide them with guidance for appropriate donning / doffing of required PPE. Policy: COVID Tracking and Cohorting CDC: PPE sequence AAPACN: Personal-Protective-Equipment-PPE-Donning-and-Doffing-Competency Indiana Department of Health: COVID 19 Infection	

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	3.1-18(b) This Federal tag relates to Complaint IN00363940.		Control for LTC facilities 9-27-21 **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with	

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			documentation of completion. To ensure Infection Control Practices are maintained, the following monitoring will be implemented. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. ensure execute proper donning and doffing of PPE, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection, including staff and visitors 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified in B1 as above. This will occur for 6 weeks and until compliance is maintained. ensure execute proper donning and doffing of PPE, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection, including staff and visitors	

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			Quality Assurance and Performance Improvement (QAPI): The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;			

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	(v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.			

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	Based on observation, interview, and record review, the facility failed to follow standard precautions while performing Covid-19 Point of Care testing for 2 of 2 staff randomly observed for Covid-19 testing (Physical Therapy Assistant 7 and Office Staff 8). Findings include: On 10/5/21 at 10:00 a.m., CNA (Certified Nursing Assistant) 5 was randomly observed performing Covid-19 POC (Point of Care) testing in the front lobby. PTA (Physical Therapy Assistant) 7 entered the building and was instructed by CNA 7 to perform a Covid-19 POC test prior to going to her work area. She was handed a collection swab and instructed to collect a nasal swab sample. She obtained the sample and placed the swab into the testing kit. CNA 7 used the testing swab handle to twist the sample inside the testing kit. She did not don gloves prior to touching the handle. She then instructed her to sit in the lobby until the test results were obtained. She sat down to wait, within 6 feet of 2 other people who were already sitting in the lobby area. Office Staff 8 entered the building and was instructed to perform a POC test due to outbreak testing. She was handed a collection swab, obtained a nasal sample, and placed it in the testing kit. She then entered an office just off the lobby. CNA 5 then moved the 2 test kits from one area of the desk to another area. She did don gloves prior to touching the test kits. The testing area did not contain a box of gloves for use during testing. During an interview on 10/5/21 at 2:15 p.m., the DON (Director of Nursing) indicated that gloves should be worn when touching the testing kits.	F 0886	**F 886** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** All residents have the potential to be affected by this alleged deficient practice. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Director of Nursing Services or designee will re-educate the staff designated for covid testing on the following policy: Standard Precautions and Transmission Based Precautions Director of Nursing Services or designee will complete a competency for obtaining an anterior nasal sway with each staff member that is designed for covid testing: **How the corrective measures will be monitored to ensure the alleged deficient practice does**	10/18/2021

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	On 10/5/21 at 2:50 p.m., the DON provided the Competency of obtaining an anterior nasal swab form, which read "...Ensure Proper PPE...if patient or employee is a self swab, follow standard precautions... On 10/5/21 at 2:50 p.m., the DON provided the Standard Precautions and Transmission Based Precautions Policy, reviewed 6/25/21, which read "...Standard Precautions are the first tier or level of precautions designed for the care of all resident's, regardless of diagnosis or presumed infection status. Implementation of the 'Standard Precautions' is the primary strategy for successful nosocomial infection control...Procedure...e. Tier I Precautions: PPE [sic] use i. Use when expectation of possible exposure to infection materials....1. Gloves a. Wear gloves when touching blood, body fluids, secretions, excretions, and contaminated items..." This Federal tag relates to Complaint IN00363940.		**not recur:** The audits and /or observations for 3 staff members designated for covid testing will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance with standard precautions during covid testing. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	