STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 00 B. WING	12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MUNCIE, THE	2400 CHATEAU DR MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00397722. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00397722 - Substantiated. Federal/state deficiency related to the allegations is cited at F880. Survey dates: December 28 and 29, 2022 Facility number: 000310 Provider number: 155443 AIM number: 100288970 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 14 Medicaid: 27 Other: 13 Total: 54 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 5, 2023.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is January 16, 2023. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after January 16, 2023.	
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 interview and record, review the facility failed to properly prevent and/or contain COVID-19 by failing to ensure staff members followed professionally accepted protocol for testing during a COVID-19 outbreak. Findings include: During a confidential interview, Employee 1 indicated during the recent outbreak, staff were routinely tested twice a week. Staff would test upon entering the facility and go to the floor to work without waiting the required 15 minutes for the test to develop. Someone would then come tell them if they were positive or negative for COVID-19.	F 0880	**What corrective action(s) will be done for residents found to have been affected by the deficient practice(s).** **It is the policy of this facility to 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.** **testing during a Covid-19 outbreak. It is the policy of the**	01/16/2023

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	During a confidential interview, Employee 2 indicated during the recent outbreak, staff were routinely tested twice a week. They would test upon entering the facility and go to the floor to work without waiting the required 15 minutes for the test to develop. During the outbreak, the employee tested positive and was sent home. During a confidential interview, Employee 3 indicated during the recent outbreak, staff were routinely tested twice a week. They would test upon entering the facility and go to the floor to work without waiting the required 15 minutes for the test to develop. They entered the facility, put their things away, then went to get tested. They did not wait to get the test results before beginning work. Someone later came to tell them they had tested positive, so they left the facility immediately. During an interview, on 12/28/2022 at 9:37 a.m., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) indicated the facility had a previous COVID-19 outbreak but was now COVID-19 free. During the outbreak, staff were instructed to test twice weekly. Staff were required to wait 15 minutes, after test performed, for the results. If they were negative they could go to the floor. If they were positive, they had to go home. Review of the facility COVID-19 collection data, indicated the facility had 35 positive COVID-19 residents from 11/27/2022 through 12/15/2022 and 28 positive staff members from 11/16/2022 through 12/18/2022. Review of the test procedure instructions from the COVID-19 test indicated the following:		**facility to ensure staff members follow professionally accepted protocol for** **Facility is Covid-free as of 12/19/22.** **Staff education was provided to all staff on professionally accepted protocol of Covid -19 testing.** **12/29/22 and 01/12/23** **Nurses and Management will have Covid-19 Competencies check off to ensure professionally accepted protocol for testing Covid – 19 outbreaks.** Facility is Covid-free as of 12/19/22. Staff education was provided to all staff on professionally accepted of Covid -19 testing protocol. Nurses and Management will have Covid-19 Competencies check off to ensure professionally accepted protocol for testing Covid – 19 outbreaks. **How facility will identify other residents having potential to be affected by practice and what corrective action will be taken.** Staff educated on 12/30/22 and 01/12/23 on facility's protocol on testing	

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	"... 4. Peel off adhesive liner from the right edge of the test card. Close and securely seal the card. Read Results in window 15 minutes after closing the card. In order to ensure proper test performance, it is important to read results promptly at 15 minutes, and not before. Results should not be read after 30 minutes...." This Federal tag relates to complaint IN00397722. 3.1-18(a)		and signs/ symptoms of Covid-19. Daily call-ins will be reviewed daily x5 days in morning meeting X 4 weeks, then 3x week x 4 weeks and monthly thereafter. Staff who experience signs/symptoms will be tested by a Nurse or Management Staff who has passed a competency check-off and will wait 15 minutes for results before leaving premises or entering workforce area. **What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur.** The DON/IP/Medical Director/ADM completed a Root Cause Analysis to identify the cause resulting in the facility failure on 01/12/23 The ADM/DON/IP or designee will review the LTC infection control assessment. Solutions and changes needed will be identified and submitted with the DPOC by 01/16/23. The DON/IP/Medical Director or designee will in-service staff on the facility infection control	

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			policy (12/30/22 and 01/12/23 and CDC guidelines regarding best ways to reduce the spread of COVID 19 virus through testing of residents / staff. Ensuring all residents/ staff that are unvaccinated/ vaccinated that test positive for COVID 19 virus or placed in transmission based precautions will adhere to facility. **How the corrective action(s) will be monitored to ensure the deficient practices will not recur. i.e., what quality assurance program will be put in place.** The DON/IP/ADM or designee will complete daily infection control rounds to ensure staff are following the Infection Control Practices and complying with all solutions identified during the completion of the RCA and LTC Infection Assessment. Rounds will be conducted daily x5 days per week for 4 weeks, then 3x week for 4 weeks and monthly thereafter. A bi- weekly QAPI on Infection Control will be held with the IDT team review and update any changes needed for sustaining compliance until facility is back in compliance	

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			and then monthly for 6 months. Results will be taken to facility QAPI monthly until Compliance is obtained. DOC:01/16/23 **The facility respectfully request a Desk review of findings.**	