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	11/14/2020

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 a COVID-19 Focused Infection Control Survey. This visit included a Residential COVID-19 Quality Assurance Walk Through. Survey date: November 14, 2020 Facility number: 000191 Provider number: 155294 Census Bed Type: SNF: 27 Residential: 25 Total: 52 Census Payor Type: Medicare: 6 Other: 21 Total: 27 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on November 20, 2020.	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 communicable diseases and infections. §483.80(a) Infection prevention and control program.			

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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	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. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

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	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 maintain an infection prevention and control program when 1 of 1 randomly observed staff member (Dietary Aide 2) failed to wear universal eye protection (goggles or face shield) during care of 2 unidentified residents in 1 of 1 dining room (The 400 Hall Dining Room). Finding includes: During an observation, on 11/14/20 at 12:17 p.m., Dietary Aide 2 was wearing a surgical mask (medical grade facemask) and no universal eye protection. She served a lunch tray to two unidentified residents in the dining room of the skilled nursing unit near the 400 Hall. The Dietary Aide 2 leaned over the two residents to set up their trays for them. The Food Services	F 0880	**F 880 Infection Prevention and Control** 1.Alleged failure of use of eye wear by Dietary Aide 2 **What corrective actions will be accomplished for those residents found to have been effected by the alleged deficient practice?** At time of survey, dining room was only being used by residents in the green zone. Immediately following guidance of surveyor, KN95s and face shields were implemented for all of health center and memory care. This practice will continue for all zones. **How other residents having the potential to be affected by the same deficient practice will be**	12/11/2020

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	Supervisor was in the dining room, at the time, the residents were being served, observing the Dietary Aide. The Food Services Supervisor was not wearing eye protection and did not advise Dietary Aide 2 to put on eye protection. During an interview, on 11/14/20 at 12:17 p.m., Dietary Aide 2 indicated she had eye goggles but was not wearing them. The Food Services Supervisor indicated they had face shields "in the back." The Indiana State Department of Health guidance, titled "COVID-19 LTC [Long Term Care] Facility Infection Control Guidance Standard Operating Procedure," updated on 10/19/20, reflected the following "...To align with updated Centers for Disease Control and Prevention (CDC) updated guidance on potential transmission by aerosol transmission, Indiana Department of Health is now recommending the use of eye protection as a standard safety measure to protect long-term care (LTC) healthcare personnel (HCP) who provide essential direct care within 6 feet of the resident in all levels of care in all long-term care facilities and assisted living...." 3.1-18(a)		**identified and what corrective action will be taken:** ·All residents in health center have the potential to be effected by this alleged deficient practice; therefore KN95s and face shields have been implemented and enforced across all of health center ·All Dietary staff, including supervisors, will be re-educated by nurse management by 12/11/2020 or prior to returning to work regarding the importance of proper use of face shields **What measures will be put in to place or what systemic changes will be made to ensure that the alleged deficient practice will not recur:** ·All Dietary staff, including supervisors, will be re-educated regarding the importance of proper use of face shields by signing off their education by 12/11/2020 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	

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R 0000 Bldg. 00			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 **How corrective actions will be monitored to ensure the alleged deficient practice will not recur IE what quality assurance program will be put in to place** ·Audit tool created by facility and approved by QSource will be completed daily X 6 weeks, weekly X 2 months then monthly X3 months in alleged deficient areas by all members of management per set schedule to cover all departments on all shifts throughout audit process ·Daily walking rounds will be completed by management team to monitor for signs of noncompliance – any areas of concern will be discussed during daily stand up. ·Results of audit tool will be presented to Administrator per audit schedule above. 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.	

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	This visit was for a Residential COVID-19 Quality Assurance Walk Through. This visit included a Nursing Home COVID-19 Focused Infection Control Survey. Survey date: November 14, 2020 Facility number: 000191 Residential Census: 25 Forum at the Crossing was found to be in compliance with 410 IAC 16.2-5 in regard to the Residential COVID-19 Quality Assurance Walk Through. Quality review was completed on November 20, 2020.	R 0000		
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program when 1 of 1 randomly observed staff members (Licensed Practical Nurse 1) failed to wear universal eye	R 0407	**R407** 1.Alleged failure of use of eye wear by LPN 1 **What corrective actions will be accomplished for those residents found to have been**	12/11/2020

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	protection (goggles or face shield) while within 6 feet of residents on the Memory Care Unit and 2 of 2 residents reviewed for COVID-19 monitoring were not consistently screened for fever, oxygen saturation (level of oxygen in the blood) and/or signs or symptoms of COVID-19 (Residents B and D). Findings include: 1. During an observation, on 11/14/20 at 11:55 a.m., Licensed Practical Nurse (LPN) 1 was walking by an unidentified male resident in the common area of the Memory Care Unit. The LPN was wearing a KN95 respirator (filtered, medical grade facemask) but was not wearing universal eye protection. A second observation, on 11/14/20 at 12:30 p.m., revealed LPN 1 escorted a female unidentified resident by holding her arm in the hallway of the Memory Unit. LPN 1 was not wearing goggles or a face shield. During an interview, on 11/14/20 at 12:30 p.m., LPN 1 confirmed the eyeglasses she was wearing were not goggles. Face shields were available at the nurses' station. The Indiana State Department of Health guidance, titled "COVID-19 LTC [Long Term Care] Facility Infection Control Guidance Standard Operating Procedure," updated on 10/19/20, reflected the following "...To align with updated Centers for Disease Control and Prevention (CDC) updated guidance on potential transmission by aerosol transmission, Indiana Department of Health is now recommending the use of eye protection as a standard safety measure to protect long-term care (LTC) healthcare personnel (HCP) who provide essential direct care within 6 feet of the		**effected by the alleged deficient practice?** Immediately following guidance of surveyor, KN95s and face shields were implemented for all of memory care. This practice will continue for all zones. **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 residents in memory care have the potential to be effected by this alleged deficient practice; therefore KN95s and face shields have been implemented and enforced across all of memory care ·All memory care staff, including supervisors, will be re-educated by nurse management by 12/11/2020 or prior to returning to work regarding the importance of proper use of face shields **What measures will be put in to place or what systemic changes will be made to ensure that the alleged deficient practice will not recur:** ·All memory care, including supervisors, will be re-educated regarding the importance of proper use of face shields by signing off their education by 12/11/2020 or prior to returning to work **How corrective actions will be monitored to ensure the alleged**	

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	resident in all levels of care in all long-term care facilities and assisted living...." 2. The record for Resident B was reviewed on 11/14/20 at 1:41 p.m. Diagnoses included, but were not limited to, vascular dementia, heart disease and hypertension. The resident's "Infection Note," dated 11/11/20, documented "Resident tested positive for COVID-19 on test collected 11/09/20." The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident B, dated 11/14/20 and provided by the Administrator on 11/14/20, documented the resident had the following orders with a start date of 08/04/20, document temperature daily every day and evening shift and monitor for signs and symptoms of COVID-19 to include nausea, vomiting or diarrhea, shortness of breath, new/change in cough, and/or sore throat every day and evening shift. An order started on 04/04/20 instructed to check his oxygen saturation during every day shift. The MAR and TAR for Resident B did not have documentation his temperature was checked on the day shift of 10/31/20. His oxygen saturation levels were not documented on 10/02/20, 10/31/20, 11/02/20 or 11/05/20. The areas in the MAR/TAR to document those orders were left blank. On 11/14/20, the facility documented his oxygen saturation level was as low as 84 percent. 3. The record for Resident D was reviewed on 11/14/20 at 1:34 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, vascular dementia, Type 2		**deficient practice will not recur** **IE what quality assurance program will be put in to place** ·Audit will be completed daily X 6 weeks, weekly X 2 months then monthly X3 months in alleged deficient areas by all members of management per set schedule to cover all departments on all shifts throughout audit process ·Daily walking rounds will be completed by memory care director, DON, or designee to monitor for signs of noncompliance – any areas of concern will be discussed during daily stand up. ·Results of audit tool will be presented to Administrator per audit schedule above. 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. ·2) Alleged failure to document or monitor for signs and symptoms of COVID-19 for (2) Memory Care residents **·What corrective actions will be accomplished for those residents found to have been effected by the alleged deficient practice?** The patient notes were also reviewed by the company's IT	

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	diabetes with diabetic retinopathy (vision impairment) and peripheral vascular disease. A "Health Status" note, dated 11/03/20, documented the resident had an elevated temperature of 100.1 Fahrenheit and was placed on isolation droplet precautions. The MAR and TAR for Resident D, dated 11/14/20 and provided by the Administrator on 11/14/20, documented the resident had the following orders with a start date of 08/04/20, document temperature daily every day and evening shift and to monitor for signs and symptoms of COVID-19 to include nausea, vomiting or diarrhea, shortness of breath, new/change in cough, and/or sore throat every day and evening shift. The MAR and TAR for Resident D did not document his temperature or monitoring for signs and symptoms of COVID-19 on the day shifts of 10/30/20 and 10/31/20. During an interview, on 11/14/20 at 4:00 p.m., the Administrator and Director of Nurses indicated nurses were expected to follow nursing standards for documentation. They did not know why the areas were blank on the residents' MARs and TARs.		department. The conclusion was made that the LPN was entering her information in a non-preferred manner. She was entering in progress notes that she was doing the checks rather than entering them into the EMAR. An email dated 11/16/2020 was sent to the surveyor per her request showing that the LPN staff member did check for signs and symptoms. **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 residents in memory care have the potential to be effected by this alleged deficient practice; therefore, all residents continue to be monitored for signs and symptoms of COVID-19 with documentation checks being completed by Director of BTR (memory care) and health center DON ·All Memory care nursing staff will be re-educated by nurse management by 12/11/2020 or prior to returning to work regarding the importance of properly documenting the monitoring of signs and symptoms for COVID-19. **What measures will be put in to place or what systemic changes will be made to ensure**	

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			that the alleged deficient practice will not recur: ·All memory care nursing staff will be re-educated regarding the importance of properly documenting the monitoring of signs and symptoms for COVID-19 by signing off their education by 12/11/2020 or prior to returning to work **How corrective actions will be monitored to ensure the alleged deficient practice will not recur IE what quality assurance program will be put in to place** ·Audit tool will be completed 5x weekly X 6 weeks, then weekly X6 weeks then monthly X3 months in alleged deficient areas by DON or designee ·Daily documentation checks will be completed by IDT team members: DON, Infection Preventionist, and Director of BTR ·Results of audit tool will be presented to Administrator per audit schedule above. 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.	