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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 00 B. WING	12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

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F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. Survey dates: December 29, 2021 Facility number: 013420 Provider number: 155831 AIM number: 201293620 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 14 Medicaid: 45 Other: 19 Total: 78 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/3/22.	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. The facility must establish an infection			

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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	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 their food, if direct contact will transmit the			

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	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, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to the use of personal protective equipment for 1 of 2 facility staff observed on the COVID unit during random infection control observations. (CNA 2) Finding includes: On 12/29/2021 at 10:05 A.M., a clear plastic barrier, labeled "Red Zone" was observed. The label included signage for required PPE (personal protective equipment) to be worn: N-95 mask, face shield, gown, and gloves when in the unit. During an observation, on 12/29/2021 at 10:22 A.M., CNA 2 was observed to put on a gown and gloves. She was noted to have a face shield on	F 0880	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey re-visit on or after **1/20/2022** A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424 effective 1/20/22022. Briarcliff Health and Rehabilitation Center must include the following in their POC for the deficient	01/20/2022

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	before she entered the resident's room. The type of mask she was wearing, was unidentifiable through the clear plastic barrier. At 10:30 A.M., CNA 2, was summoned to approach the barrier. She identified herself by name, and indicated when she had gone into the resident's room, she had been wearing a surgical mask. When interviewed as to why she was not wearing an N-95 mask as indicated on the Red Zone sign, CNA 2 indicated she thought since she was wearing a face shield, it was acceptable to wear a surgical mask. She indicated there were N-95 masks available on the unit, in the drawer. During an observation of the 600 unit, "Red Zone", on 12/29/2021 at 11:06 A.M., CNA 2 was again requested to come to the plastic unit barrier. CNA 2 was observed to be wearing a surgical mask, with an N-95 mask around her neck. She indicated she was going to use the N-95 mask when she entered a the resident's rooms and use the surgical mask when she was not with residents. On 12/29/2021 at 11:58 A.M., the Director of Nursing indicated anyone working in the Red Zone should be wearing an N-95 mask. Interview with the Administrator, on 12/29/2021 at 1:30 P.M., indicated CNA 2 was from a nursing agency. The Administrator also indicated the Infection Preventionist, who had been on vacation prior to December 13, 2021, would be responsible for monitoring PPE usage. In her absence, the Director of Nursing and Nursing unit managers, as well as other department heads, monitored PPE usage on a daily basis. During an interview with the Director of Nursing, on 12/29/2021 at 2:55 P.M., she indicated the		practice cited at F880: **A. Specific/Immediate: Immediately implement specific plan for resident/residents/area/others identified in the deficiency to correct.** 1). The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff 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. All staff will be educated on proper PPE use according to CDC procedures and facility policy. **A. Systemic** 1). A root cause analysis (RCA) was conducted by the facility with input and review from the Medical Director, IP, Executive Director, Director of Nursing, Director of Clinical Operations and Corporate Nurse Consultant to determine the root cause resulting in the facilities Infection Control citation. a). Through staff interviews, it was determined that CNA # 2 lacked proper understanding of proper use of PPE. Staff failed to read signage present on doorway and reported that she thought it was acceptable to wear surgical mask in area where n95 was	

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	nursing agency was responsible for education regarding transmission based precautions and use of proper personal protective equipment. 3.1-18(b)		required. The facility leadership team failed to ensure full implementation of continuous mandatory PPE requirements through clear education and direct observation – Staff must wear proper PPE according to zones. b). The solutions and systemic changes developed by the Division (Consultant IP), DON, ADON and facility IP include: The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff 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. For this education and return demonstration, the following resources will be used: • CDC Guidance: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 • CDC Guidance: Interim Infection Prevention and Control • CDC Guidance: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic · PPE use by zone	

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			· Personal Protective Equipment (PPE) Donning and Doffing Competency Tool The DON, IP or Designee will ensure all staff involved are 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. The DON, IP, or designated facility leadership will conduct full / all department facility rounds at a minimum of daily to ensure staff are wearing PPE appropriately while in the facility and enforce corrective measures and education if deficiencies are observed. 2). The DON, IP Nurse, Corporate Nurse Consultant and Director of Clinical Operations reviewed the LTC Infection Control Self-Assessment. Changes were made to so the assessment would now be an accurate reflection of the facility. This assessment will be submitted with the DPOC documentation. **C. Training:** 1).Per the LTC infection control assessment review and revision by The DON, IP Nurse, Corporate	

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			Nurse Consultant and Director of Clinical Operations, The following training needs were identified and implemented by the Division (Consultant) IP to the facility IP and DON with training resources and polices provided and submitted as part of the DPOC documentation. · Proper use of PPE per Zone The Director of Nursing (DON), Infection Preventionist (IP) or Designee will educate the facility staff on how and when to don and doff eye protection. For this education and return demonstration, the following resources will be used: · CDC Guidance: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 · CDC Guidance: Interim Infection Prevention and Control · CDC Guidance: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic · PPE use by Zone · Personal Protective Equipment (PPE) Donning and Doffing Competency Tool The DON, IP or Designee will	

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			ensure all staff involved are 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. The DON, IP or Designee will post the CDC Guidance: Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 for visual reminders for staff **D. Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained.** The DON, IP, or designated facility leadership will conduct full facility / all department rounds at a minimum of daily for 6 weeks and until compliance is maintained: to ensure staff are wearing PPE appropriately while in the facility and enforce corrective measures and education if deficiencies are observed. The DON, IP, or designated facility leadership will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and ensure the CDC Guidance: Use Personal Protective Equipment (PPE) When Caring for Patients with	

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			Confirmed or Suspected COVID-19 for visual reminders for staff. This will occur for 6 weeks and until compliance is maintained. **E. Quality Assurance and Performance Improvement (QAPI):** The IP Nurse/Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 6 months. 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. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	