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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 the Investigation of Complaint IN00341191. This included the COVID-19 Focused Infection Control Survey. Complaint IN00341191 - Substantiated. Federal/state deficiency related to the allegation is cited at F880. Survey date: November 12, 2020 Facility number: 000576 Provider number: 155701 AIM number: 100267760 Census Bed Type: SNF/NF: 50 SNF: 2 Total: 52 Census Payor Type: Medicare: 22 Medicaid: 17 Other: 13 Total: 52 These deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1 Quality review completed November 13, 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			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the development and transmission of 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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 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 ensure all staff were screened at the beginning of their shift for any signs or symptoms of illness (RN1, RN 2 and CNA 3). The facility also failed to ensure infection control practices were followed related CDC guidelines for Transition Based Precautions (TBP) isolation for 2 of 3 residents reviewed for admission or readmission to the facility. (Resident B and C) Findings included: 1. During review of the employee screening log at 11/12/20 at 1:29 p.m., RN 1 worked on the Covid-19 unit on November 6, 7 and 8. The facility was	F 0880	Plan of Correction - Citation #1 Facility failed to ensure all staff were screened at the beginning of their shift for any signs or symptoms of illness (RN1, RN2, and CNA3). **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Staff will undergo active symptom screening at the	12/11/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	unable to determine if the employee had been screened prior to starting her shift. RN 2 worked on the Covid-19 unit on 11/9/20. The facility was unable to determine if the employee had been screened prior to starting her shift. CNA 3 worked on the Covid-19 unit on 11/2, 11/4, 11/5 and 11/8/20. The facility was unable to determine if the employee had been screened prior to starting her shift. During an interview on 11/12/20 at 3:06 p.m., the Director of Nursing (DON) indicated they recently transitioned all Covid-19 positive residents onto 1 hall. The previous unit was too small. Staff who had tested positive in the past for Covid were able to come through a separate entrance into the unit and all other staff should have come through the front door to be screened. She thought the entrance door should now be locked, but they just moved all the residents 11/11/20. Staff who were scheduled to work on the previous Covid-19 unit could have been going into the unit by the outside door and not get screened. All 3 staff tested negative for Covid-19. 11/12/20 at 3:10 p.m., the DON, along with the Administrator, indicated she sent out a video last night which indicated who needed to be screened at the front door. 2. The clinical record for Resident C was reviewed on 11/12/20 at 12:37 p.m. Diagnoses included, but were not limited to, after-care, hypertension, depression and pain. Resident C was admitted to the facility on 10/6/20 following a hospital admission. He was placed in		beginning of their shift in order to prevent, identify and control infections and communicable diseases for all residents. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;** - To identify if other residents had the potential to be affected, screening logs were reviewed by HFA and DON and compared against work schedules. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;** *Corrective Measure:* Ensure all staff are actively screened prior to starting their shift and screening is documented. COVID negative and COVID recovered staff are to be screened at Door 12. COVID positive staff working in the COVID unit enter at Door 8, don PPE and be actively screened by another staff member in the unit before entering unit. *Systemic Change:* The main staff entrance is manned from 5 am – 5 pm with an individual actively screening COVID negative and COVID	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	room 229-A with Resident B. A progress note, dated 10/10/20 at 3:43 p.m., indicated Resident C was up for lunch and then stated he did not feel well. The resident was pale and sweaty. His blood glucose level was 134 mg/dL. His vital signs included a pulse of 70 bpm, blood pressure 124/70 and temperature was 97.0 Fahrenheit. The nurse then checked his oxygen saturation and it was 82%. The nurse left the room to get an oxygen concentrator and found the resident unresponsive. A second nurse was called to assist and determined the resident no longer had a pulse. During an interview on 11/12/20 at 2:10 p.m., the DON indicated they were a little behind with starting the 14-admission isolation. She was not sure if it was related to bed availability. A current facility policy, revised 3/2020, provided by the Administrator on 11/12/20 at 4:50 p.m., titled "COVID-19 RESPONSE PLAN," indicated the following: "POLICY: In order to prevent and minimize the spread of infection related to the Covid-19 pandemic. PROCEDURE: ...II. Prevention Steps a. Practice good hand hygiene...... b. Follow regulatory guidance on restriction of visitors. c. Direct all traffic through one entrance.... ...d. Perform screening at the permitted entrance.... VII. Shelter in Place Protocol a. If a resident is confirmed or presumed to have COVID-19, facility will attempt to reduce the interaction.... i. When possible, utilize a private room with the		recovered staff as they enter Door 12. A wireless doorbell has been implemented for after hours. The doorbell enables the Nursing staff to respond to anyone entering the building after 5 pm. Signage (Exhibit 1) is posted at Door 12. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place)** -All staff screenings are documented on the team member log (Exhibit 2). Daily team member screening logs from COVID negative entrance will be reviewed by third shift nurse using Team Member Screening Log Audit Checklist (Exhibit 5), and provided to Director of Nursing. Any issues will be noted with submitted logs and addressed by DON, Administrator or designee. COVID positive unit screening logs will be reviewed and initialed by the unit nurse each shift. -- Directed Plan of Correction - Citation #1 **Section A: Systemic Change** Root Cause Analysis WHAT HAPPENED An unused wing of the facility (Magnolia Hall) was designated as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	door closed...." This Federal Tag relates to complaint IN00341191. 3.1-18(b)(1)		the COVID unit on the evening shift of 10/27/20. Asymptomatic COVID positive team members scheduled in the COVID unit were entering the facility at Door 14. On 10/28/20 at the request of the Administrator, area surveyor Julie Call confirmed with supervisor Christine Foderea that screening of positive staff was not necessary, note they are asymptomatic positive. COVID negative staff should enter the normal facility entrance and be screened prior to reporting to the COVID unit. From 10/28-11/10 several COVID negative staff that were working in the COVID unit entered the building using Door 14 to advance to the COVID unit without being screened for signs or symptoms at the beginning of their shift. CONTRIBUTING FACTORS Opening of COVID unit was sudden and unplanned, several processes involving the flow of staff, food, linens, supplies, trash, etc needed to be determined in a short period of time. This area of the building was opened, then expanded, then relocated all within 15 days. COVID negative staff thinking they are working in the COVID unit should not be in any other part of the building therefore used the entrance that led directly to the unit. COVID negative staff watching and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			following other staff (COVID+) enter through Door 14 without clarifying if this is the correct entrance. Facility scrambling to find staff willing and able to cover shifts in the COVID positive unit that communication of all details was limited. Infection Prevention Nurse herself was providing resident care in the COVID positive unit vs. in an office generating memos of communication. No sign at the entrance indicating who should use Door 12 and who should use Door 14. SOLUTIONS Staff education by DON via video on entrance use, where and how COVID positive staff and COVID negative staff are to be screened; appropriate door signage. Infection Control Assessment Review – completed on 12/2 (See Exhibit 3). **Section B: Training** All staff provided re-education of proper entrances, how staff will be screened and why (Exhibit 4). **Section C: Monitoring** Daily team member screening logs from COVID negative entrance will be reviewed by third shift nurse using Team Member Screening Log Audit Checklist (Exhibit 5), and provided to Director of Nursing. Any issues will be noted with submitted logs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			and addressed by DON, Administrator or designee. COVID positive unit screening logs will be reviewed and initialed by the unit nurse each shift. COVID positive unit screening logs will be submitted to the Director of Nursing with any issues being addressed by DON, Administrator or their designee. This will occur for 6 weeks and until compliance is maintained. The IP nurse/DON/designee will complete daily visual inspections of the staff screening process to ensure all corrective and systemic measures are being followed. Daily observations will be recorded on the Daily Observation Audit Log (Exhibit 6). Any issues will be reported to the Administrator. This will occur for 6 weeks and until compliance is maintained. **Section D: Quality Assurance Process Improvement** The Administrator will present a report to the QAPI committee monthly for 6 months. The QAPI committee will provide any recommended changes to the DPOC initiatives needed for ensuring substantial compliance during that time. Citation #2 - Plan of Correction	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			1. Facility failed to ensure infection control practices were followed related CDC guidelines for Transmission Based Precautions (TBP) isolation for 2 of 3 residents reviewed for admission or readmission to the facility (Resident B and C). **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No corrective actions will be taken as both residents affected are no longer living. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;** -A review of all new residents admitted within the last 60 days confirmed that only one other new admission occurred since 10/6/20. This new resident was placed in a single room under TBP quarantine for 14 days. -Other existing residents returning from hospitalizations have been properly isolated since 10/19/20 in accordance with updated ISDH guidance which states, “Residents in this category (‘yellow’) are to remain in TBP for full 14 days.” (p. 2, COVID-19 LTC Facility Infection Control Guidance Standard	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Operating Procedure). -All other re-admissions were done according to ISDH guidance which indicated that, “asymptomatic residents who have had a negative test,” and do not have clinical uncertainty surrounding their COVID-19 status, or “have negative COVID-19 testing during hospitalization,” are “acceptable for transfer to LTCFs.”(p. 2, COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated 7/23/20)(p. 2, COVID-19 Guidance for Hospital Discharge to Long-Term Care Facilities, updated 8/17/20). **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;** *Corrective Measure:* Educate admissions personnel, interdisciplinary team, and other relevant staff on changed ISDH guidance for admitting residents from hospital or other settings to long-term care setting. *Systemic Change:* Health Facility Administrator will ensure that updated ISDH guidance – related to resident admissions to long-term care settings - is properly distributed to all staff in a timely manner of effective changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

How the corrective action(s) will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place):
-The IP nurse/DON/designee will complete daily visual audit of new resident admissions to ensure thatnew resident admissions are following proper ISDH guidance related to admitting residents from hospital or other settings to long-term care settings.

By what date the systemic changes for each deficiency will be completed:
-Educate relevant staff – To be completed by December 11, 2020.
-Monthly audit report to QAPI Committee beginning January 2021.

--

Directed Plan of Correction - Citation #1

Section A: Systemic Change
Root Cause Analysis
WHAT HAPPENED
Two residents with fracture diagnosis were placed together in a semi-private room upon admission/readmission to facility without first being isolated for 14 days with TBP in place.
CONTRIBUTING FACTORS
· Lack of available bed-space

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			in nursing unit to isolate two male residents. · Residents were identified to be COVID-19 Negative (Green) due to being asymptomatic, had tested negative prior to arrival at LTC facility, and were considered Category 1 patients – for whom there is no clinical concern for COVID-19 (e.g. no fever, no new cough, and no shortness of breath) – which was consistent with ISDH guidance for admitting the residents to our facility (p. 2, COVID-19 Guidance for Hospital Discharge to Long-Term Care Facilities, updated 8/17/20), p. 2, COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated 7/23/20). SOLUTIONS Health Facility Administrator will ensure that updated ISDH guidance – related to resident admissions to long-term care settings - is properly distributed to all staff in a timely manner of effective changes. **Section B: Training** Educate admissions personnel, interdisciplinary team, and other relevant staff on changed ISDH guidance for admitting residents from hospital or other settings to long-term care setting. **Section C: Monitoring** The IP nurse/DON/designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155701	A. BUILDING 00 B. WING	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHRISTIAN CARE RETIREMENT COMMUNITY	720 E DUSTMAN RD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			complete daily visual audit of new resident admissions - using Exhibit 7 - to ensure that new resident admissions are following proper ISDH guidance related to admitting residents from hospital or other settings to long-term care settings. **Section D: Quality Assurance Process Improvement** The Administrator will present a report to the QAPI committee monthly for 6 months. The QAPI committee will provide any recommended changes to the DPOC initiatives needed for ensuring substantial compliance during that time.	