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
	155475	A. BUILDING 00 B. WING	09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWNE HOUSE RETIREMENT COMMUNITY	2209 ST JOE CENTER RD FORT WAYNE, IN 46825

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F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. Survey date: September 21, 2021 Facility number: 000541 Provider number: 155475 Census Bed Type: SNF: 2 Residential: 203 NCC: 35 Total: 240 Census Payer Type: Medicare: 2 Other: 238 Total: 240 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 23, 2021	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 observations, interviews and record reviews, the facility failed to follow prevention measures related to COVID -19 through resident monitoring and staff screening for 1 of 5 residents reviewed for infection control (Resident 4), and 1 employee for 12 shifts reviewed (Employee 5). Findings include: 1. The record for Resident 4 was reviewed on 9/21/21. The record did not indicate Resident 4 was monitored daily for signs and symptoms of COVID-19 since December of 2020. During an interview on 9/21/21 at 12:37 P.M., the Director of Nursing (DON) indicated the COVID-19 monitoring order for Resident 4 was not in the computer. The resident had changed rooms after he had Covid-19. She indicated the computer system required the facility to treat	F 0880	Indiana State Department of Health Brenda Buroker, Director Long Term Care Re: COVID-19 Focused Infection Control Survey for our facility The Towne House Retirement Community (ID: 000541/ Provider #: 155475) **F880** Infection Prevention & Control **Problem Statement:** Facility failed to complete required monitoring of residents that were displaying signs and symptoms of COVID-19 · Staff failed to document the required monitoring related to a resident with signs and symptoms of COVID-19	10/11/2021

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	residents as new admits when they changed rooms and all orders would be re-entered. She indicated the COVID-19 monitoring must have gotten missed. The DON indicated there was no documentation of Resident 4 having been monitored for signs and symptoms of COVID-19 since the last order dated 12/5/2020. The DON indicated they only had vital sign checks for temperature and oxygen saturations daily. The DON indicated cough and shortness of breath would be included in the COVID-19 signs and symptoms monitoring. 2. The COVID-19 staff and visitor screening logs were reviewed. The screening logs for Employee 5, dated September 1, 5, 6, 7, 8, 10, 13, 14, 15, 16, 17, and 20, 2021 indicated Employee 5 had written "HIPPA" at the top of the questionnaires and failed to answer any of the questions. All except of the forms ecept the one dated September 1 were signed off as having had been checked by Employee 3, Employee 6, or Employee 7. During an interview on 9/21/21 at 10:30 A.M., the DON indicated Employee 5 was a nurse and was not vaccinated. During an interview on 9/21/21 at 10:45 A.M., Employee 5 indicated she screened herself at door 3 because she is a nurse so that was acceptable. Employee 5 indicated she did not answer any of the questions because it was HIPPA (HIPAA, Health Insurance Portability and Accountability Act) and was nobody's business if she had been vaccinated, or if she had signs or symptoms of COVID-19. When asked why she did not respond to the signs and symptoms questions, Employee 5 indicated she did not even know if the screening log was asking for signs		· Staff failed to ensure that the orders for required documentation were added to the residents profile · Lack of knowledge and/or lack of adherence to the facilities policies and procedures related to the documentation requirements for a resident that is displaying signs and symptoms of COVID · Need for re-education and increased monitoring related to documentation requirements for resident with and/or displaying signs/symptoms of COVID-19. **Problem Statement:** Facility failed to ensure that all employees were screened using the current guidelines and process outlined in the facility's policies and procedure · Staff self-screening when reporting to work and forms not being filled out completely as required by IDOH guidelines and facilities policies and procedures · Staff refusing to answer required questions on screening and still reporting to duty · Staff signing screening sheets when discovering during audits of the forms that no screener was present and/or didn't sign the sheets · Lack of knowledge and/or adherence to the facilities policies and procedures related to the employee/visitor screening process Need for re-education and	

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	and symptoms, and she indicated she was not told it was okay to self screen. During an interview on 9/21/21 at 10:46 A.M., Employee 6 indicated the receptionist screened her in upon arrival to work, and indicated the staff can't self screen. During an interview on 9/21/21 at 10:48 A.M., Employee 4 indicated the staff screen themselves in when nobody was there to review anything. During an interview on 9/21/21 at 10:49 A.M., Employee 1 indicated the receptionist screened her in around 7:10-7:15, and someone was always at door 4. During an interview on 9/21/21 at 10:52 A.M., Employee 2 indicated she came in around 10:00 A.M., so the receptionist screened her in at door 4. During an interview on 9/21/21 at 11:15 A.M., the DON indicated Employee 3 worked South hall, employees were not to self screen, and the receptionists should not be signing screening logs of people they had not screened. During an interview on 9/21/21 at 12:30 P.M., the Administrator indicated employees should be checking in with whomever was assigned at door 3 and if nobody was there they were to check with the nurse. She indicated the receptionists were responsible for monitoring the screening logs. During an interview on 9/21/21 at 10:58 A.M., Employee 3 indicated she worked 7 A.M. to 3:30 P.M. and would typically arrive around 6:40-6:45		increased monitoring related to employee screening process Corrective Actions: · Perform a Root Cause Analysis and develop/implement needed solutions/system changes to address findings within the RCA – October 7, 2021 · In-services o Staff in-serviced on policy and procedure for employee screening process o In-service on policy and procedures related to residents displaying signs/symptoms of COVID-19 - · Bi – annual Infection Control education/in-services will be performed for all staff including a general overview as well as, specific infection control guidelines for each department within the facility including documentation requirements as well as screening process · Orientation – in addition to the required infection control training will implement departmental specific infection control guidelines for each department within the facility to include documentation requirements for licensed staff and screening process for all staff. ·Monitoring Tools to be completed Daily to ensure infection control practices are being followed	

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	A.M. Employees were to enter door 4, where her desk was located, to be screened in. She indicated there were other receptionists from 3 P.M.-6 P.M. at door 4. Employee 3 indicated between 6 P.M. and 7 A.M., staff were to go through door 3 and get screened. She indicated someone was supposed to be signing the screening sheets, but when nobody was screening at door 3, then she would sign them even though she was not here to do the screenings. Employee 3 indicated that sometimes nobody was stationed at door 3 so she signed the screening logs for Employee 5. Employee 5 entered the building through door 3. Employee 3 indicated she noticed Employee 5 had not been answering the screening questions, but did not tell anyone because Employee 5 had told her it was not their business. Employee 3 indicated staff were to enter door 1 or door 4 on arrival to work during the day shift. The facility policy titled "Infection Infection Prevention & Control of COVID-19," undated, indicated "The facility will determine which specific entrances to designate as the main entrances. These entrances shall have a means for actively screening all who enter, and a means to alert for illness or exposure presence. ... Once the screening tool is completed on the individual, the decision can be made to either allow the employee to work, or the essential visitor, to visit or to deny work or visits. ... Any person in close contact ... would be considered "potentially exposed". The risk for a person depends on various factors. Following these factors as a guide to make educated decisions on whether or not to isolate at home can be used. However, the CDC guidance demonstrates that an employee can continue to work and do not have to isolate for 10 days as long as they are symptomatic, ...		·Appropriate Infection Control r/t employee screening requirements, ·Daily times 6 weeks – for POC ·Weekly times 2 months ·Monthly times 3 months ·Audits will be reviewed by QAPI Committee and the QIO/IP Consultant to identify trending of missed opportunities and will adjust DPOC as warranted. ·Facility will implement this monitoring on a routine quarterly basis ·Quarterly monitoring will be random and will cover all shifts ·Monitoring Tools to be completed Daily to ensure infection control practices are being followed ·Appropriate Infection Control r/t required COVID-19 documentation ·Daily times 6 weeks – for POC ·Weekly times 2 months ·Monthly times 3 months ·Audits will be reviewed by QAPI Committee and the QIO/IP Consultant to identify trending of missed opportunities and will adjust DPOC as warranted. ·Facility will implement this monitoring on a routine quarterly basis ·Quarterly monitoring will be random and will cover all shifts	

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	4. Prophylactic measures and treatment Each community shall monitor for symptoms of fever, cough, and shortness of breath. ...." 3.1-18(a)		·Review of Focus Survey elements to ensure compliance in all areas as well as a review of facility self-assessment (Attachment A) - conducted by QIO/Infection Preventionist Consultant – to be scheduled throughout the project period ·Resources from QIO on an ongoing basis throughout the project time period. Start date: October 7, 2021 End Date: April, 2022 Midway check point: January 2022 Final Check and Wrap up: April 2022 Touch base meetings onsite with Qsource IP consultant: November 2021 Monthly monitoring tools and evaluation of progress will be done at touch base and mid way check point meetings. Attachments provided: Root Cause Analysis Directed Plan of Correction (DPOC) Facility Screening Fit for Duty Policy Screening Training Documents QAPI Audit form for Daily Screening Thank you, Amy Riegling, Executive Director	

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