| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 12/01/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAPMAN PLACE | 3110 E COLISEUM BLVD<br>FORT WAYNE, IN 46805 |

| (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 |
|---|---|---|---|---|
| R 0000<br><br>Bldg. 00 | This visit was for a Residential COVID-19 Quality Assurance Walk Through.<br><br>Survey date: December 1, 2021<br><br>Facility number: 010235<br><br>Residential Census: 42<br><br>These state residential findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed Decmebr 1. 2021 | R 0000 | *Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.* | |
| R 0407<br><br>Bldg. 00 | 410 IAC 16.2-5-12(b)(1-4)<br>Infection Control - Noncompliance<br>(b) The facility must establish an infection control program that includes the following:<br>(1) A system that enables the facility to analyze patterns of known infectious symptoms.<br>(2) Provides orientation and in-service education on infection prevention and control, including universal precautions.<br>(3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. | | | |

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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| | (4) Reporting communicable disease to public health authorities.<br><br>Based on observation and interview the facility failed to ensure proper handwashing during 1 of 1 observations affecting 1 resident. (Resident J)<br><br>Findings include:<br><br>During a tour of the facility on 12-1-21 at 8:42 AM, CNA 1 was observed in a room identified as being in Transmission Based precautions. The CNA had on gown, gloves, a mask and facshield. She was exiting the room with a tray of disposable food containers. She properly doffed (took off) her gown, and gloves after disposing of the containers at the door of the room. She then picked up the tray with ungloved hands and took it to te kitchette. The CNA was not observed to sanitize her hands.<br><br>In an interview, on 12-1-21 at 8:56 AM, RN 1 indicated the CNA should have taken the containers into the room with out the tray and not brought the tray back into the hallway. She indicated the CNA should have washed her hands. | R 0407 | **R 407 Infection Control – Noncompliance**<br>/b><br>CNA 1 was re-educated by the Regional Care Specialist on 12/1/2021 on hand hygiene. Attachment 1<br><br>**2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**<br>The Regional Care Specialist completed an observational audit of infection control practices with residents in transmission based precautions on 12/2/2021 to ensure hand hygiene is being performed appropriately. No concerns were identified.<br><br>**3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:**<br>The Executive Director and the Regional Care Specialist were re-educated on 12/1/2021 by the Regional Director of Care Services on hand hygiene. Attachment 2. Current staff were re-educated on 12/2/2021 by the Regional Care Specialist on hand hygiene. Attachment 3 | 12/30/2021 |

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| | | | **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br>The Executive Director is responsible for sustained compliance. The Care Services Manager or designee will complete observational audits of infection control practices with residents in transmission based precautions 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks to ensure hand hygiene is performed appropriately. Results of the spot checks will be discussed in the monthly QI meetings until 80% compliance is achieved for 6 consecutive months. The QI Committee will determine if continued auditing is necessary based on 6 consecutive months of compliance. Monitoring will be on-going.<br><br>**5 By what date the systemic changes will be completed**<br>Completion date: 12/30/2021 | |