STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. BUILDING 00 B. WING	01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REHABILITATION CENTER AT HARTSFIELD VILLAGE	503 OTIS R BOWEN DR MUNSTER, IN 46321

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F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. Survey date: January 3, 2022 Facility number: 010758 Provider number: 155662 AIM number: 200229550 Census Bed Type: SNF/NF: 18 SNF: 64 Total: 82 Census Payor Type: Medicare: 72 Medicaid: 1 Other: 9 Total: 82 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/10/22.	F 0000		
F 0880 SS=E 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 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.

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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, 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 a CNA wearing a cloth face mask from the start of her shift while taking care of residents who were in Transmission Based Precautions (TBP). This had the potential to affect all residents residing on the first floor. Finding includes: During a random observation on 1/3/22 at 10:00 a.m., CNA 1 was observed wearing a cloth face mask over her mouth and nose. She was walking around the first floor. During that time, every room but 1 was in TBP. Interview with CNA 1 on 1/3/22 at 10:14 a.m., indicated she arrived to work at 6:00 a.m., and	F 0880	**F880** 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. The facility failed to ensure infection control guidelines were in place related to one staff member who was observed wearing a cloth face mask on the first floor where patients were in transmission based precautions. **Corrective action taken for residents found to have been affected by the deficient**	01/23/2022

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	there were no N95 face masks available for her to wear, so she put on her cloth face mask. She was unaware she could not wear the cloth face mask while taking care of the residents. She indicated she had entered the TBP rooms while wearing her cloth face mask. Interview with LPN 1 on 1/3/22 at 10:25 a.m., indicated she arrived at work at 7:00 a.m. and there were plenty of N95 face masks available and face shields to use. She was unaware CNA 1 was wearing a cloth face mask and entering TBP rooms. Interview with the first floor ADON (Assistant Director of Nursing) on 1/3/22 at 10:30 a.m., indicated all staff were to use their N95 face mask 1 time and throw it away at end of their shift. The N95 face masks were readily available at the nurses' station, the front desk or in the education room. All staff working on the first floor were required to wear a N95 face mask and face shield during the entire shift. She was unaware CNA 1 was wearing a cloth face mask. Follow up interview with the first floor ADON on 1/3/22 at 3:40 p.m., indicated CNA 1 was taking care of 14 residents, all were in TBP except for 1 resident who was in the green zone. The current and updated 11/22/21 "Indiana Department of Health COVID-19 Infection Control Guidance in Long-term Care Facilities" policy indicated "Direct and indirect care HCP (Healthcare Professional) should wear a medical procedure mask for the duration of their shifts. N95 respirator mask should be worn in COVID-19 units and with any resident who is symptomatic or in TBP (red or yellow zone) awaiting testing. While supplies are limited, masks should be		**practice:** The facility provided 1:1 education to the staff member identified. Education was also provided to all staff to ensure a thorough understanding of how and when to properly DON/DOFF PPE, as well as the location(s) where additional PPE is readily available throughout the facility. Additional instructional signage related to PPE accessibility was placed throughout patient care areas as well as the reception / screening area. **Identification of other residents having the potential to be affected by the same deficient practice:** All patients on the 1st Floor had the potential to be affected. **To ensure that proper practices continue:** The Director of Nursing and facility Infection Preventionist re-educated facility staff regarding requirements for PPE based on transmission based precautions utilized for each patient care zone (green, yellow, red) as well as the proper practice to DON/DOFF PPE. Education also focused on the location(s) where additional PPE is readily available throughout the facility. The education provided strongly reinforced the importance of proper use of PPE for the provision of	

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	conserved and only a single mask should be worn by HCP each shift. N95 mask may only be removed (doffed) five times before it should be discarded. Masks should be changed when visibly soiled or wet. When possible, by supply and lower transmission in the facility, mask use can return to conventional usage and NIOSH-approved N95 respirators." 3.1-18(b)		safe patient care. Signage remains in place facility wide to identify PPE requirements, location of additional PPE and proper practice to DON/DOFF PPE. The Director of Nursing/Designee will initiate a monitoring tool to document daily observations of staff to ensure that appropriate PPE is being utilized correctly. Visual rounds will be conducted in patient care areas throughout the facility to ensure compliance with this Plan of Correction. Audits will be conducted for six weeks and will be reviewed by the Administrator and/or Infection Preventionist in order to identify trends to discuss with the facility's QAA Committee. After successful completion of the six week monitoring period, the QAA Committee will review all audit tools to determine if the facility has achieved 100% compliance with practices, at which time the monitoring will cease. If the QAA Committee determines that less than 100% compliance has been achieved, the monitoring tools will continue for another six week period and will again be reviewed by the QAA Committee. This practice will continue until the facility has achieved 100% compliance. The systemic plan is to randomly	

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			initiate the audit tool monthly over the next six months to ensure this deficient practice will not recur. **Quality Assurance Plan to monitor compliance with this Plan of Correction:** Identified concerns shall be reviewed by the facility's QAA Committee. Findings from all audit tools will continue to be reviewed monthly by the QAA Committee for the next six months. Recommendations for further corrective action will be discussed and implemented as needed.	