STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 00 B. WING	11/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(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 a COVID-19 Focused Infection Control Survey. Survey dates: November 8, 2020 Facility number: 002982 Provider number: 155700 AIM number: 200382090 Census Bed Type: SNF/NF: 61 SNF: 6 Total: 67 Census Payor Type: Medicare: 10 Medicaid: 33 Other: 24 Total: 67 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on 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 the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control			

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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	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 under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin			

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	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 observation, record review and interview, the facility failed to ensure direct care staff followed the current State and CDC (Center for Disease Control) guidance for the use of protective eyewear on their Yellow Zone (a unit that residents who have been exposed or suspected of being exposed to COVID-19). This deficient practice had the potential to affect all residents who reside in the facility. (Employee 1, Employee 2 & Employee 3) Finding includes: During a tour of the Yellow Zone, conducted on 11/8/2020 at 3:30 P.M., the following was observed: Employee 1 was observed wearing a N95 mask but no eyewear in the hallway.	F 0880	Plan of Correction for Survey Event 23PC11 dated November 8, 2020 F880 (S=D)—Infection Prevention and Control What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice? - No residents were affected How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - Testing for COVID-19 took place for coworkers and residents on 11/11/20 and contact tracing for anyone that tested positive was completed.	12/11/2020

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	Employee 2 and Employee 3 were observed sitting next to each other giving report. Each were wearing a N95 mask neither were observed wearing eyewear. During an interview, conducted with the Assisted Director of Nurses, on 11/8/2020 at 4:30 P.M., she indicated staff were to be utilizing either a faceshield or goggles on the Yellow Zone. The Indiana Infection Prevention Toolkit, last updated 10/30/2020, indicated "To align with updated Centers for Disease Control and Prevention [CDC] updated guidance on potential transmission by aerosol transmission, Indiana Department of Health is now recommending the use of eye protection as a standard safety measure to protect long-term care [LTC] healthcare personnel [HCP]...." 3.1-18(b)(2)		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? - Identified additional areas for coworkers to give report socially distanced. - PPE Cards for each unit were designed, produced, and handed out to coworkers (please see attached) to place behind badges. - Education provided to coworkers (please see attached) o November 25th, 30th and ongoing 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? - Nurse manager or designee to do walking rounds 5 days a week X 30 days, weekly X 2 months, and monthly X 3 months, to ensure proper PPE is being wore/correctly by coworkers and that report is being conducted socially distanced. By what date the systemic changes for each deficiency will be completed? - The systemic changes will be completed by December 11, 2020.	