STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/30/2023

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00403915 and Complaint IN00403984. Complaint IN00403915 - No deficiencies related to the allegations are cited. Complaint IN00403984 - No deficiencies related to the allegations are cited. Survey dates: March 29 and 30, 2023. Facility number: 014512 Residential Census: 125 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 31, 2023	R 0000	April 14, 2023 RE: Survey Event ID VFUP11 To Whom It May Concern: On March 30, 2023, a State Residential Licensure with Complaint (IN00403915, IN00403984) was conducted at our community Evergreen Village at Fort Wayne by the Division of Long Term Care, Indiana Department of Health, to determine if the facility was in compliance with state requirements for health facilities found at 410 IAC 16.2. Complaint IN00403915 and IN00403984 did not have deficiencies related to the allegation cited. State Residential Licensure survey resulted in findings that were cited. Please see attached Plan of Correction related to those findings attached. We have also attached documents related to the Plan of Correction. Evergreen Village at Fort Wayne is asking for a desk review on this Plan of Correction. If you have any questions I can be reached at 260-637-2830 or emailed at execdir@evergreenvillage-fortwayne.com	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Etter	Executive Director	04/14/2023

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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			Sincerely, Laura Etter Executive Director	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete			

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	a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure a health screen and tuberculosis skin testing were performed for 1 of 5 employee files reviewed. Finding include: During a record review conducted at 8:45 AM on 3/30/23, Certified Nurse Aide (CNA) 2's employee file was reviewed. According to the employee file, CNA 2 was hired on 10/13/22. Neither an employee health screen nor Mantoux testing records were available for review. During an interview conducted at 8:50 AM on 3/30/23 with the Administrator, she indicated CNA 2 had a health screen and Mantoux skin testing performed by a previous employer. The Administrator indicated upon her review of the file, the records were not present and had not been collected. The Administrator indicated all staff members should have a health screen and Mantoux testing performed upon hire. A form titled Employee Health Screen, undated, was provided by the Administrator at 1:32 PM on 3/30/23 for review. The form indicated a health screen shall be required of all employees prior to resident contact.	R 0121	R121 410 IAC 16.2-5-1.4(f)(1-4) Personnel It is the policy of this community to ensure a health screen and Two-Step TB test using the Mantoux method (5TU,PPD) is obtained and kept in the personnel record for all employees with the health screen and first step TB being completed and read prior to resident contact unless a previously positive reaction can be documented. The results shall be recorded in millimeters of induration with the date given, date read, and by whom administered. Then going forward annually each employee should be screened for tuberculosis. (Attachments A) **What corrective action(s) will be accomplished for those residents (staff) found to have been affected by the deficient practice?** No staff were affected by this deficient practice. A health screen was completed for CNA 2 on 3-30-23 (Attachment B) A first step TB test was completed for CNA 2 on 3-30-23 and read	04/28/2023

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	A policy titled Tuberculosis Skin Testing and Follow-Up for Employees and Residents, last revised 9/13/21, indicated the facility must assure that at the time of employment, or within one month prior to employment, employees should be screened for tuberculosis.		with negative results on 4-1-23 (Attachment C) A second step TB test was completed on 4-13-23 with results to be read within 72 hours and documented. (Attachment D) **How will the facility identify other residents (staff) having the potential to be affected by the same deficient practice and what corrective action will be taken?** A full audit of Mantoux testing and health screen documentation for all employees will be completed by 4/15/2023. Employee files found out of compliance will be resolved by gathering the necessary missing information to achieve 100% compliance. (Attachment E) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** The management team was educated on 4-13-23 regarding the policy and process of health screens and TB testing prior to employment. (Attachment F) A new hire checklist (Attachment G) was created to ensure all employee files have accurate and appropriate pre-employment forms present to include a health screen, two-step TB testing, and annual signs and symptoms for TB. The administrative assistant will ensure this checklist is completed	

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			and hand to the business office manager for review prior to filing. **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?** Administrative assistant or designee will audit 25% of employee files monthly for the next 6 months to ensure ongoing compliance. Administrative assistant or designee will forward any areas follow-up to the manager of that employee and the Executive Director for follow up if compliance is not achieved. Any ongoing issue or concerns will be forwarded to the QAPI team for follow up and resolution. (Attachment E) **By what date the systemic changes will be completed.** 4/28/2023	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food items were dated upon opening in the kitchen. 125 of 125 residents residing in the facility ate food prepared in the kitchen. Findings include:	R 0273	R 273 410 IAC 16.2-5-5.1 (f) Food and Nutritional Services It is the policy of this community to ensure all food preparation and serving areas are maintained in accordance with state and local sanitation and safe food handling	04/28/2023

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	During a kitchen tour with the Dietary Manager (DM) on 3/29/23 beginning at 9:05 AM, a container with a clear lid covering half a cream pie was observed in the walk-in refrigerator. No open date was visible anywhere on the package. A bag of blueberries observed in the walk-in freezer was visibly cut open and tied closed. No open date was visible anywhere on the package. In the dry storage room, a jar of chicken base was observed about 1/3 full and no open date was visible on the jar. 3 bags of cereal and 3 bags of pasta were observed to be about ½ full and wrapped closed with clear plastic wrap. No visible date was noted on any of the bags. A stack of 3 trays of eggs were observed in the reach-in cooler. No date was visible on the eggs. The salad station cooler had containers of shredded cheese and boiled eggs with no dates on the containers. During an interview on 3/29/23 at 9:14 AM, the DM indicated all open items must be dated when opened to prevent accidentally serving expired food. She indicated she became busy at times and forgot to date the packages when opening them. A policy titled Ready-to-Eat Hazardous Food, Date Marking Policy and Procedure, undated, was presented on 3/30/23 at 8:50 AM by the Administrator for review. The policy indicated all ready-to-eat foods shall be clearly marked to indicate the date or day by which the food must be discarded. The policy also indicated the container should be marked at the time of opening.		standards. **What Corrective action will be accomplished for those residents found to have been affected by the deficient practice?** On 3-30-23 all opened items that were found in the freezer, dry storage, and walk in cooler to not have open dates were immediately thrown away. The salad station was completely cleared out and cleaned with fresh items stocked and labels placed on each item identifying them and the date they were put into the salad station. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by this deficient practice. On 3-30-23 a 100% audit was done to ensure that there were not any other food items opened without dates clearly labeled on them in all areas of the kitchen. (Attachment M) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Dietary staff were educated on 3-30-23 policy named Ready to Eat Hazardous Food, Date Marking regarding labeling and dating of opened items.	

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			(Attachment N) Dietary Manager or designee will audit freezer, dry storage, walk in, and salad station to ensure accuracy of labeling and dating items that are opened for 100% compliance on a weekly basis for the next 6 months. (Attachment O) **How the corrective actions will be monitored to ensure the deficient practice will not recur, ie. What quality assurance program will be put into place and by what date will the systemic changes be completed?** Dietary Manager or designee will audit freezer, dry storage, walk in, and salad station to ensure accuracy of labeling and dating items that are opened for 100% compliance weekly for the next 6 months. Any issues or concerns will be forwarded to the Executive Director and QAPI team for follow up and resolution. **By what date the systematic changes will be complete.** 4-28-23	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of			

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	symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on record review and interview, the facility failed to ensure resident's annual tuberculosis skin test or risk assessment was completed in 5 of 6 residents reviewed. (Resident 2, Resident 3, Resident 4, Resident 6, and Resident 7). Findings include: 1. On 3/29/23 at 2:25 PM, Resident 2's record was reviewed. Diagnoses included osteoporosis, pre-diabetes, coronary artery disease and a history of transient ischemic attack. The resident's Checklist of Signs & Symptoms of TB indicated a last review date of 9/20/21. Resident 2's TB Skin Test Screening Record, dated 9/20/21, indicated the resident consented to receive TB testing (a screening method developed to evaluate an individual's status for active TB or Latent TB infection). 2 TB skin tests were administered on 9/20/21 and 10/6/21 and read 3 days later which resulted in 0 millimeter (negative) wheal. Resident 2's Immunization Record was reviewed. The record indicated, on 9/20/21, the resident received 0.1 milliliter Tubersol injection (an injection placed within the skin used to detect TB) into her left forearm which was read on 9/23/21 and resulted in 0 millimeter. The record indicated, on 10/6/21, the resident received 0.1 milliliter Tubersol injection into her right forearm which was read on 10/8/21 and resulted in 0 millimeter wheal.	R 0412	R 412 410 IAC 16.2-5-12(i) Infection Control It is the policy of this community to ensure an annual risk assessment is completed for the development of symptoms suggestive of tuberculosis, including, but not limited to cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. (Attachment A) **What corrective action(s) will be accomplished for those residents (staff) found to have been affected by the deficient practice?** No residents were affected by this deficient practice By 4-15-23 TB risk assessment will be completed for resident's 2, 3, 4, 6, and 7 (Attachment I) On 3-30-23 DON identified annual risk assessments that had not been completed for residents in 2022 and initiated an improvement action plan (QAPI) dated March 2023 indicating an audit of charts showing non-compliance. DON assigned 4-26-23 for 100% compliance and April as the designated month for ongoing annual compliance. (Attachment J) Due to non-compliance DON or	04/28/2023

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	In an interview on 3/30/23 at 3:45 PM, the DON indicated TB testing or risk assessment for TB should be done annually. She indicated Resident 2's last TB test was done 10/6/21 and the resident should have had a TB test or risk assessment annually. 2. On 3/30/23 at 9:42 AM, Resident 3's record was reviewed. Diagnoses included anxiety, depression, atrial fibrillation, diabetes mellitus, hypertension, and transient ischemic attack. The resident's Checklist of Signs & Symptoms of TB indicated a last review date of 11/4/21. Resident 3's TB Skin Test Screening Record, dated 11/4/21, indicated the resident consented to receive TB testing. 2 TB skin tests were administered on 11/4/21 and 11/19/21 and read 3 days later which resulted in 0 millimeter (negative) wheal. Resident 3's Immunization Record was reviewed. The record indicated, on 11/4/21, the resident received 0.1 milliliter Tubersol injection into her right forearm which was read on 11/7/21 and resulted in 0 millimeter wheal. The record indicated, on 11/19/21, the resident received 0.1 milliliter Tubersol injection into her left forearm which was read on 11/21/21 and resulted in 0 millimeter wheal. In an interview on 3/30/23 at 3:45 PM, the DON indicated TB testing or risk assessment for TB should be done annually. She indicated Resident 3's last TB test was done 11/19/21 and the resident should have had a TB test or risk assessment annually.		designee will complete annual risk assessment on all residents residing in community by 4-28-23 for 100% compliance. **How will the facility identify other residents (staff) having the potential to be affected by the same deficient practice and what corrective action will be taken?** A full audit of all residents will be completed by 4-15-23 to identify any resident out of compliance and an annual risk assessment for TB will be completed to achieve 100% compliance by 4-28-23. (Attachment K) **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?** Licensed Nursing Staff were educated on 4-13-23 regarding the policy and process of annual risk assessments on all residents residing in community. (Attachment L) DON or designee will track ongoing compliance of residents receiving annual risk assessments to ensure ongoing compliance of 100%. DON has designated April each year to review and complete ongoing annual risk assessments for TB. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

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	3. On 3/30/23 at 10:35 AM, Resident 4's record was reviewed. Diagnoses included anxiety, diabetes mellitus, acquired absence of right leg below the knee amputation, hypertension, and phantom pain. The resident's Checklist of Signs & Symptoms of TB indicated a last review date of 9/24/21. Resident 4's TB Skin Test Screening Record, dated 9/24/21, indicated the resident consented to receive TB testing. 2 TB skin tests were administered on 9/24/21 and 10/11/21 and read 3 days later which resulted in 0 millimeter (negative) wheal. Resident 4's Immunization Record was reviewed. The record indicated, on 9/24/21, the resident received 0.1 milliliter Tubersol injection into her left forearm which was read on 9/27/21 and indicated a negative result. The record indicated, on 10/11/21, the resident received 0.1 milliliter Tubersol injection into her left forearm which was read on 10/13/21 and indicated a negative result. In an interview on 3/30/23 at 3:45 PM, the DON indicated TB testing or risk assessment for TB should be done annually. She indicated Resident 4's last TB test was done 10/12/21 and the resident should have had a TB test or risk assessment annually. 4. On 3/30/21 at 11:48 AM, Resident 6's record was reviewed. Diagnoses included chronic pain, depression, enlarged aortic root, paralysis of both lower limbs, and seizures. The resident's Checklist of Signs & Symptoms of TB indicated a last review date of 4/14/21.		**assurance program will be put into place?** DON or designee will audit 25% of resident charts monthly for the next 6 months to ensure ongoing compliance. DON or designee will forward any areas of concern to the Executive Director and to the QAPI team for follow up and resolution. **By what date the systemic changes will be completed.** 4/28/2023	

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	Resident 6's TB Skin Test Screening Record, dated 4/15/21, indicated the resident consented to receive TB testing. 2 TB skin tests were administered on 4/15/21 and 4/29/21 and read 3 days later which resulted in 0 millimeter wheal. Resident 6's Immunization Record was reviewed. The record indicated, on 4/15/21, the resident received 0.1 milliliter Tubersol injection into his right forearm which was read on 4/18/211 and resulted in 0 millimeter wheal. The record indicated, on 4/29/21, the resident received 0.1 milliliter Tubersol injection into his left forearm which was read on 5/1/21 and resulted in 0 millimeter wheal. In an interview on 3/30/23 at 3:45 PM, the DON indicated TB testing or risk assessment for TB should be done annually. She indicated Resident 6's last TB test was done 4/29/21 and the resident should have had a TB test or risk assessment annually. 5. On 3/30/21 at 1:52 AM, Resident 7's record was reviewed. Diagnoses included anemia, chronic kidney, coronary artery disease, depression, dysphasia, hypertension, diabetes mellitus, and cognitive communication deficit. The resident's Checklist of Signs & Symptoms of TB indicated a last review date of 11/12/21. Resident 7's TB Skin Test Screening Record, dated 11/12/21, indicated the resident consented to receive TB testing. A TB skin test was administered on 11/12/21 and 11/29/21 and read 3 days later which resulted in 0 millimeter wheal. Resident 7's Immunization Record was reviewed. The record indicated, on 11/12/21, the resident			

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	received 0.1 milliliter Tubersol injection into her left forearm which was read on 11/15/21 and indicated a negative result. The record indicated, on 11/29/21, the resident received 0.1 milliliter Tubersol injection into his right forearm which was read on 12/1/21 and indicated a negative result. In an interview on 3/30/23 at 3:45 PM, the DON indicated TB testing or risk assessment for TB should be done annually. She indicated Resident 7's last TB test was done 11/29/21 and the resident should have had a TB test or risk assessment annually. In an interview on 3/30/23 at 2:52 PM, the Administrator indicated all residents in the facility were required to have annual TB test or risk assessment. She indicated Residents 2, 3, 4, 6, and 7 had not had a TB test or risk assessment done in the last 12 months and should have. On 3/30/23 at 2:25 PM, a Quality Improvement Action Plan (QAPI), dated March 2023, provided by the DON, indicated an audit of charts showed not all annual TB assessments were completed for residents and documented in the resident's chart as an area of concern. The QAPI indicated the facility had set a 100% compliance goal by 4/26/2023 to complete all resident annual sign and symptom surveys, document results in the resident's chart and designate April as "TB Month" for annual TB compliance going forward. On 3/30/22 at 1:32 PM, a current policy titled "Tuberculosis Skin Testing and Follow-Up for Employees and Residents", last approved 9/13/21, provided by the Administrator, indicated a sign and symptom checklist would be completed annually for residents.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN VILLAGE AT FORT WAYNE	12523 AUBURN ROAD FORT WAYNE, IN 46845

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