

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 155586	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/22/2020
NAME OF PROVIDER OF SUPPLIER LUTHERAN LIFE VILLAGES		STREET ADDRESS, CITY, STATE, ZIP 6701 S ANTHONY BLVD FORT WAYNE, IN 46816	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices during the Covid-19 pandemic were followed on 1 of 6 units in the facility. (Birch Hall) Findings include: During the entrance conference on 9/22/2020 at 8:49 a.m., the Administrator indicated a Covid-19 unit was created in response to the positive testing of residents on 9/17/2020. The unit was located at the end of Birch hall with a plastic sheeting wall as a barrier with a center zippered opening. A copy of the facility floorplan provided by the Administrator indicated the Covid-19 unit consisted of six rooms (215 through 220) and accommodated seven residents positive for the Covid-19 virus. During a tour of the facility on 9/22/2020 at 9:55 a.m., the DON (Director of Nursing) indicated the double doors were closed to each unit/hallway off of the central lounge. She indicated the 200 hall, Birch, housed the Covid-19 unit. Signs for Contact and Droplet Precautions were observed posted on the double doors to Birch hall. The DON indicated there were dedicated staff for the Covid-19 unit and a nurse and a QMA (Qualified Medication Aide) were assigned to Birch hall. The DON indicated the Covid-19 rooms were in the back part of the Birch hall and there was not an exit used to the outside from the Covid-19 unit. The double door exit led to an unused area (A and B Extended) of the nursing facility, which was used for storage. According to the floor plan, there were 3 exit doors marked in the unused A and B-extended areas. During an interview with Nurse 1 on 9/22/2020 at 10:26 a.m., she indicated she was working in the Covid-19 unit along with an aide. The nurse indicated she wore an N95 mask, a gown, which was used for the shift, and goggles. The nurse indicated there was not a medication cart in the Covid-19 unit and when it was time to pass the residents' medications, she would exit the Covid-19 unit through the zippered entrance. The medication cart for the residents in the Covid-19 unit was located outside the Covid-19 unit on the other side of the barrier, which was identified by the Administrator as a green or clean area. The nurse indicated she would remove her gown and then unzip the barrier and enter into the non-Covid-19 part of Birch hall. The nurse indicated she would prepare the medications in resident identified medication cups on an overbed tray table and then she would enter the Covid-19 unit via the zippered barrier, don her gown, use hand foam, don gloves and then park the overbed tray table at each resident's doorway and administer the medications to each resident. At the end of the shift, Nurse 1 indicated she would leave her gown in the Covid-19 unit and exit through the zippered barrier and wear her N95 mask and goggles down Birch hall to her office. Once in her office, Nurse 1 indicated she would remove her N95 mask and goggles and leave them in the office and she would don a surgical mask. Nurse 1 indicated to leave the facility, she would exit Birch hall through the double steel doors, walk through the central lounge area and out the front doors of the facility. During an interview with Nurse 4 on 9/22/2020 at 1:59 p.m., in Birch Hall just outside the plastic barrier separating the Covid-19 unit from the rest of Birch hall, she indicated she was the nurse who worked Birch Hall outside of the Covid-19 unit on this date. Nurse 4 indicated the only time she went into the Covid-19 unit, was this morning to answer a call light for a resident. Nurse 4 indicated there was not a QMA working in Birch Hall. An observation of CNA 2 (Certified Nurse Assistant) on 9/22/2020 at 2:00 p.m., indicated the CNA entered the clean side of Birch hall from the Covid-19 unit through the zippered barrier, leaving her gown inside the Covid unit. The CNA indicated she had just assisted another staff with lifting a resident in the Covid unit. An observation of CNA 3 in the Covid-19 unit on 9/22/2020 at 2:10 p.m., indicated she was observed to remove her gown in the Covid-19 unit and entered the clean side of Birch hall through the zippered barrier without removing her shoe covers. The CNA was observed to adjust her goggles with her hand and then she was observed to wash her hands at the sink in the nurse station. An observation of CNA 2 on 9/22/2020 at 2:12 p.m., indicated the CNA was on the clean side of the Covid-19 unit and donned a clean gown. She entered the Covid-19 unit through the zippered barrier and used hand foam. CNA 3 was also observed to enter the Covid-19 unit from the clean side with her shoe covers on her shoes. She donned her gown and used hand foam. Both CNA 2 and CNA 3 were observed to go into a resident's room to assist the resident who had activated his call light. During an interview with Nurse 1 on 9/22/2020 at 2:18 p.m., indicated she did not wear shoe covers. She removed her shoes once she left the building. The nurse indicated it was customary for the staff to go back and forth through the zippered opening from Birch hall, clean side to the Covid 19 unit. She indicated the staff only enter and exit through the front of the facility and there was not a separate exit for staff to leave the Covid-19 unit except through the clean side of the facility and out through the front doors. A current policy, Coronavirus (Covid-19) Prevention & Response was last revised on 7/22/2020 and provided by the Administrator on 9/22/2020 at 1:00 p.m. The policy indicated .Cohort residents with Covid-19, if needed, following current CDC (Center for Disease Control) guidelines The current CDC guidance, Responding to Coronavirus (Covid-19) in Nursing Homes was updated on 4/30/2020 and located on the CDC.gov website. The guidance indicated for resident cohorting, .assign dedicated HCP (Healthcare Personnel) to work only on the Covid-19 care unit. At a minimum this should include the primary nursing assistants and nurses assigned to care for these residents. HCP working on the Covid-19 unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility .Assign dedicated resident care equipment to the cohort unit The current CDC guidance, Preparing for Covid-19 in Nursing Homes was updated on 6/25/2020 and located on the CDC.gov website. The guidance indicated .Identify Space in the facility that could be dedicated to monitor and care for residents with Covid-19 .and .Identify HCP who will be assigned to work only on the Covid-19 care unit when it is use</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.