| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **155835** | A. BUILDING _____ B. WING _____ | **03/31/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **SYMPHONY OF CROWN POINT LLC** | **1555 S MAIN STREET CROWN POINT, IN 46307** |

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) |
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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to maintain an infection control program related to not wearing a face mask properly during direct resident care, not performing hand hygiene after touching the front of used personal face masks, wearing gloves outside of resident rooms, and not wearing the proper PPE (personal protective equipment) in a resident room with droplet precautions for 2 of 4 random observations and for 2 of 4 isolation rooms with possible cases of COVID 19. (Residents E, F, and D) Findings include: 1. During a random observation on 3/31/20 at 8:55 a.m., LPN 1 was observed walking into a resident room with a personal face mask around her neck. She spoke with the resident and left the room and immediately walked into another resident room with the mask around her neck. The mask was not covering her face and her nose and mouth were exposed. The LPN was instructed to place the mask over her face to cover her mouth and nose. She was observed touching the front and sides of the mask with her bare hands, lifting it over her mouth and nose. After placing the mask back over her face, she continued to speak with the resident. She was instructed she needed to perform hand hygiene after touching the front of the mask. Interview with LPN 1 at that time, indicated she was aware the mask was supposed to be over her mouth and nose while providing direct care with residents. 2. During a random observation on 3/31/20 at 9:00 a.m., Resident E was observed in their room. At that time, there were 2 therapy staff also observed in the room. One therapist had her back to the door, sitting in a chair speaking with the resident and PT (Physical Therapist) 1 was standing next to the bed typing on his computer. PT 1 was observed with a personal face mask covering his mouth only, his nose was not covered. The therapist was instructed to pull the mask up over his nose. After placing the mask over his nose with his bare hands, he continued to type on the computer. At that time, he was instructed to perform hand hygiene after touching the front of the mask. Interview with the Director of Therapy on 3/31/20 at 1:30 p.m., indicated PT 1 should have been wearing his personal mask over his mouth and nose during direct care with a resident. Interview with the Director of Nursing on 3/31/20 at 1:45 p.m., indicated direct care staff were supposed to be wearing personal face masks over their mouth and nose at all times. Hand hygiene was to be performed if the outside of the mask was touched. An inservice for Reuse or Extended use of Face Masks, provided by the Infection Control Nurse on 3/31/20 at 2:58 p.m., indicated Storage and Donning of used face masks: If mask needs to be removed, leave the patient area. Do not touch the outside of the face mask. If contact occurs, clean hands with soap and water or alcohol based sanitizer before and after touching/adjusting the mask for wear. 3. During an observation on 3/31/20 at 9:10 a.m., CNA 1 was observed walking down the hallway wearing gloves on both hands. At that time, she was carrying a breakfast tray for Resident F, who was in droplet isolation for possible COVID 19. Interview with CNA 1 at that time, indicated she had donned her gloves a little while ago. Interview with the Director of Nursing on 3/31/20 at 1:45 p.m., indicated staff were not supposed to be walking down the hallway with gloves on their hands. 4. During an observation at 9:25 a.m., CNA 1 was observed standing inside Resident D's room by the foot of his bed holding a roll of plastic garbage bags. At that time, the resident was in his room and there was an isolation set up hanging on the room door with a sign indicating the resident was in droplet isolation. The resident's room door was wide open and not closed. The CNA was wearing a hand made cloth personal face mask over his mouth and nose and had gloves to both of his hands. He was not wearing goggles or any other protective eye wear to his face. Interview with CNA 2 at that time, indicated he was unaware why the resident was in droplet isolation. The record for Resident D was reviewed on 3/31/20 at 1:50 p.m. The resident was admitted on [DATE] from the hospital. [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) assessment, dated 3/15/20 indicated the resident was alert and oriented. physician's orders [REDACTED]. The resident's temperature log indicated the following: [DATE] 99.3 degrees Fahrenheit [DATE] 99.5 degrees Fahrenheit 3/14/20 100.7 degrees Fahrenheit 3/15/20 102.5 degrees Fahrenheit [DATE] 101.3 degrees Fahrenheit A Nurse Practitioner's (NP) Progress Note, dated 3/15/20 at 5:26 p.m., indicated per nursing he has had fevers documented since yesterday. Infectious work up ordered and pending including chest X-ray, urinalysis, blood cultures, and flu swab. A physician's orders [REDACTED]. A NP Progress Note, dated 3/17/20 at 5:56 p.m., indicated the patient continued with fevers and was noted with a cough despite intravenous antibiotic treatment. The chest X-ray, obtained on 3/16, was negative. The patient has noted swelling to the non-surgical leg and his left knee has pain and swelling. A venous doppler was obtained and was negative. The urinalysis was obtained, showed white blood cells in the urine and the preliminary showing culture indicating greater than 100,000 of Gram Negative Bacilli. A NP Progress Note, dated [DATE] at 11:05 a.m., indicated the resident's blood cultures were negative as well as the flu swab. Interview with the Administrator on 3/31/20 at 8:40 a.m., indicated the local hospital had reached out to them and indicated they would come to the facility and perform COVID 19 testing if they had residents with signs and symptoms. The Administrator indicated 2 nurses from the hospital came out on [DATE] and tested 4 residents, and were told results would be back in 3-5 days. Two of those residents were Residents D and F. On 3/24/20, the Physician was notified and indicated the results still showed pending. On 3/25/20, the lab company was notified and indicated they had no results and that it could take up to a week. On 3/27/20, the lab was notified and again informed the facility still no results. On 3/30/20, the lab supervisor was notified and informed the facility they were not validated to perform the test until 3/24/20, however the 4 tests were sent to another lab facility in North Carolina on 3/23/20. On 3/30/20, the new lab company was notified and indicated to the facility it was taking longer than expected and all nursing homes and rehab facilities were a priority, however the 4 tests from the facility were not listed as a priority. Interview with the Director of Nursing on 3/31/20 at 1:45 p.m., indicated CNA 2 should have been wearing a disposable face mask and goggles or some other protective eye wear in a resident's room with droplet precautions. The current CDC (Center for Disease Control) droplet precautions indicated everyone must clean their hands before entering and leaving the room. Make sure their eyes, nose, and mouth were fully covered before room entry and remove face protection before room exit. This Federal tag relates to Complaint IN 368 3.1-18(b) 3.1-18(l) |

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.