STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155104	A. BUILDING _____ B. WING _____	**10/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE CENTER	**1201 W BUENA VISTA RD EVANSVILLE, IN 47710**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program during the COVID-19 crisis for 3 of 3 residents observed. Residents were not provided facial coverings during personal care, staff were observed with masks under their chins, and face masks were observed outside of their paper storage bags. (Resident 79, Resident 112, RN 1, CNA 2, CNA 3) Findings include: 1. On 10/23/20 at 8:58 a.m., CNA 1 was observed to provide personal care to Resident 79. After providing care, CNA 2 entered the resident's room and assisted CNA 1 with transferring the resident to a recliner. The resident lacked a face mask or facial covering and no facial covering was offered throughout the care or transfer. On 10/23/20 at 1:46 p.m., CNA 2 indicated the residents only wore masks when they exited their rooms. 2. On 10/23/20 at 9:43 a.m., 23 masks and opened paper bags with masks in them, were observed sitting in cubicles in the employee breakroom. During an observation on 10/23/20 at 9:15 a.m., employee masks were observed in brown paper bags in a cubby storage unit. Masks were stored in brown paper bags, and some had the masks on top of the bags. All 23 bags were open to air, with the breakroom door open to the hallway. The same was observed on 10/23/20 at 12:40 p.m. During an interview with CNA on 10/23/20 at 10:25 a.m., she indicated employee masks are stored at the end of shift in the breakroom in a cubby. They are placed in a brown paper bag and are to be rolled closed to seal them. 3. On 10/23/20 at 12:33 p.m., RN 1 was observed to be sitting in the nurse's station with her mask under her chin and no face shield or eye protection on. There were 3 other staff members in the nurse's station at the time. On 10/23/20 at 1:05 p.m., RN 1 indicated she thought she only needed to wear her mask when she was providing direct resident care. While indicating this, RN 1 did not have a face shield or eye protection on. 4. On 10/23/20 at 12:55 p.m., CNA 3 was observed to provide personal care to Resident 112. The resident lacked a face mask or facial covering and no facial covering was offered throughout the care. The clinical record for Resident 112 was reviewed on 10/23/20 at 12:39 p.m. [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment, dated 7/15/20, indicated the resident had moderate cognitive impairment. A care plan included, but was not limited to, follow facility policy for COVID-19 screening/precautions, start date 3/16/20. On 10/23/20 at 1:02 p.m., Resident 112 indicated the staff never had her cover her face when they provided care, only when she would sit in her chair or leave her room. On 10/23/20 at 1:04 p.m., CNA 3 indicated the residents only wore face masks when they were outside of their rooms but was not aware they were not aware they needed them while providing care. The residents do not wear them in the shower either, only when they were transported to and from the shower room. During a review of the current policy, N95 Use, Reuse, and Storage, dated 9/16/20, provided by the Administrator on 10/23/20 at 1:59 a.m., indicated, Place respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. To minimize cross-contamination, store respirators so they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly. Employees should place their designated N95 mask in a brown paper sack and store in the sack and inside their designated location assigned. During a review of the current policy, Face Shield/Eye Protection Policy, undated, provided by the Administrator on 10/23/20 at 1:59 p.m., indicated, All staff will be provided with a face shield or eye protection while providing care to residents . During a review of the current policy, Mask Policy, undated, provided by the Administrator on 10/23/20 at 1:59 p.m., indicated, Direct care staff will be given N95 mask to wear during their shift. All other staff will wear procedural masks. Type of mask usage is subject to change based on Infection Preventionist recommendations. On 10/23/20 at 2:02 p.m., the Director of Nursing indicated the facility did not have a specific written policy related to resident mask use during care. 3.1-18(b) 3.1-18(l)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE