STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING _____ B. WING _____	**10/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY NURSING AND REHABILITATION CENTER	**1236 LINCOLN AVE EVANSVILLE, IN 47714**

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 implement infection control measures to prevent the spread of COVID-19. Staff did not change gloves or wash hands between tasks when providing resident care for 2 of 2 observations of care. Staff did not encourage residents to wear a mask in the hall for 12 of 23 residents leaving the dining room after lunch. Residents eating in the dining room were not social distanced. Staff touched their face masks and did not sanitize after for 1 of 2 residents observed for care. (Resident 36, Resident 15, Resident 42, Resident 25, Resident 32, Resident 21, Resident 51, Resident 49) Findings include: 1. On 10/23/20 between 8:49 A.M. and 9:08 A.M., the following random observations were made: a. Resident 42 and Resident 25 were observed sitting on opposite sides of the common area outside of rooms [ROOM NUMBERS]. Neither resident had on a face mask. During that time, RN 11 walked past Resident 42 and Resident 25 without asking them about a face mask. Resident 42 indicated he had a face mask with him, but staff had not reminded him to put it on. Resident 42 then took out his face mask, and put it on. Resident 25 was unable to be interviewed. b. Resident 32 was observed sitting in a chair across from room [ROOM NUMBER] without a face mask, and indicated at that time staff did not ask her to wear a face mask when in the hall. She indicated she had only been asked to wear a face mask when going down for therapy. c. Resident 21 and Resident 51 were observed sitting in recliners beside each other in the common area outside of rooms [ROOM NUMBERS]. Neither resident had on a face mask. Resident 21 indicated at that time We don't have to wear a mask in the hall, it's our choice, but we do have to wear one if we leave the building. d. Resident 49 was observed walking with a walker in the 1st floor hall without a face mask on. She indicated at that time staff had not asked her to wear a face mask while in the hall. 2. On 10/23/20 at 9:12 A.M., CNA 7 and CNA 9 were observed cleaning Resident 15 in her bed. Upon entering the room, CNA 9 was observed to have gloves on. CNA 7 was observed coming into Resident 15's room from another resident room, did not wash or sanitize her hands, and put on gloves. CNA 7 opened a drawer, took out a peri spray bottle, and after assisting to turn the resident to her right side, sprayed her backside. CNA 7 then opened a drawer, obtained a tube of zinc, and applied the zinc to the resident's backside. Resident 15 was then assisted to her back. CNA 7 adjusted the resident's boots and raised the bed with the same gloved hands. She then removed the blanket from the bed, and while folding it in half, the blanket raked the floor. The blanket was then used to cover the resident. CNA 7 then handed the call light and bed control to the resident, and opened 3 drawers looking for bags. She then wrapped all dirty rags and towels in another towel, and took her gloves off. CNA 7 did not wash or sanitize her hands after removing the gloves. She then applied lotion to Resident 15's face with bare hands. 3. On 10/23/20 at 11:27 A.M., CNA 15 was observed to assist Resident 36 with a shower. CNA 15 stood very close to the resident's face, pulled down her face mask with bare hands, and talked to the resident, who was not wearing a face mask. CNA 15 did not wash or sanitize her hands, then put on a pair of gloves and assisted Resident 36 to stand. CNA 15 pulled the resident's pants and brief off, and assisted the resident to sit on the seat of her rollator walker. CNA 15 continued to assist Resident 36 to clean, rinse and dry. No towel was laid on the rollator walker seat, and the seat was not cleaned before the resident sat down after she had been showered. After the shower, CNA 15 got a clean brief, and assisted Resident 36 to pull on the brief and a pair of clean pants. CNA 15 pulled her face mask down under her chin, and put it back on. CNA 15 then touched the rollator walker, opened a drawer, leaned on a nightstand with her left gloved hand, got out a pair of socks, and put those socks on the resident. CNA 15 then pulled her face mask down and put it back on. She then touched her face mask again, and put the resident's shoes on. CNA 15 touched her face mask again, and took off the gloves she had put on before beginning the shower. CNA 15's bare hands were visibly wet. With her bare hands, she took a dirty rag and towel, and placed them in the shower. She then washed her hands for 16 seconds. Then with bare hands, CNA 15 touched her mask, got Resident 36's toothbrush and toothpaste, turned on the faucet, put her hands on her hips touching her scrubs, touched her face mask, touched her hair, touched her face mask again, got a cup for Resident 36, put up her toothpaste and toothbrush, and touched her face mask again. Then CNA 15 took the paper towel that the resident had used to wipe her mouth, and threw it away. She assisted her to brush her hair, assisted the resident into her recliner, opened the curtains, handed her a newspaper, picked up a soiled rag and dirty dishes, and left the room. CNA 15 was not observed to wash her hands before leaving the room. During an interview at that time, CNA 15 indicated staff should wash their hands when entering a resident room, when leaving a resident room, when taking off or putting on gloves, or when hands or gloves are visibly soiled. She indicated hands should be washed for at least 20 seconds. At the time of the interview, CNA 15 was observed to touch her face mask 1 time, and not sanitize her hands after. 4. On 10/23/20 from 11:48 A.M. to 12:49 P.M., the following was observed in the Dining Room during lunch service: a. RN 11 was observed to come very close to Resident 42's face at the table he was sitting, pull down her face mask and talk to the resident, who was not wearing a mask. Resident 42 left the dining room not wearing a mask, and returned 2 minutes later, not wearing a mask. b. 23 residents were observed sitting in the dining room. All were sitting at 2 at a table, with the exception of 1 resident sitting alone. At 8 of the tables with 2 residents, the residents were sitting at opposite ends of the table, facing one another. At the 3 remaining tables with 2 residents, the residents were sitting closer to one another, and not across the table. c. Before lunch was served, 1 of 23 residents sitting in the dining room was wearing a mask. d. After lunch service, 9 of 23 residents left the dining room wearing a face mask on their own accord. 4 of the remaining 14 residents were encouraged to wear a face mask when leaving the dining room. The remaining 10 residents did not wear a face mask when leaving the dining room, and were not encouraged to do so. e. After lunch service, Maintenance 3 measured the dining room tables, and indicated they were 47 3/4 inches in diameter(slightly over four feet), and that all the tables in the dining room were the same size. Residents seated at the tables could not social distance from each other while eating. During an interview on 10/23/20 at 1:30 P.M., the DON (Director of Nursing), who was also the facility IP (Infection Preventionist) indicated all staff had been trained on all infection control practices, including hand hygiene, glove use, and face mask use. She indicated gloves should be put on before providing care, changed if dirty or between dirty and clean tasks, and hands should be sanitized between glove changes. She further indicated staff should encourage all residents to wear face masks in the hall. The DON also indicated staff should not touch their face masks, and if they do they knew to sanitize after. At that time, the Administrator indicated each resident had a mask use and social distancing form on their door. The Administrator also indicated each resident had a current care plan for being uncomfortable wearing a face mask in the building, including intervention, but not limited to, encourage mask use. During an interview on 10/23/20 at 2:40 P.M., the Administrator indicated they would accept the citations (from the Focused Infection Control Survey), then continue to do the same thing they were doing, because staff had already been trained, and there was only so much training that could be done. On 10/23/20 at 2:14 P.M., the following forms were provided: a. A form titled PER CDC GUIDELINES AND THE RECOMMENDATION OF ISDH FOR THE SAFETY OF ALL RESIDENTS LIVING IN SKILLED NURSING FACILITIES, THE FOLLOWING IS IN EFFECT AS OF 9/23/20, that indicated . All residents will be asked to wear a mask when outside their room and in common areas . Residents will need to wear a mask on the way to and from meals in the Dining Room . Residents maintain social distancing of 6 ft when outside of room and around others .,

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) dated 9/23/20. b. A form titled Daily Updates for University Nursing and Rehabilitation, that indicated . residents provided masks as warranted or requested and encouraged to wear outside of room ., dated 9/20. c. A current Handwashing/Hand Hygiene policy, revised 8/15, that indicated . All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . It also indicated to wash hands when hands are soiled, use an alcohol-based hand rub before and after direct contact with residents, before moving from a contaminated body site to a clean body site during care, after contact with a resident's skin, and after assisting residents with personal hygiene. The policy indicated hands should be washed for a minimum of 20 seconds, and hand hygiene should be performed before applying gloves, and after taking them off. 3.1-18(b) 3.1-18(l)