STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING _____ B. WING _____	**10/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH PARK NURSING CENTER	**650 FAIRWAY DR 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** - Few	**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 ensure infection control practices were maintained to mitigate the spread of COVID-19. Staff exited the room of a resident who was on droplet precaution isolation with a used disposable gown while rolling the gown up against their clothing for one of one staff observed. Staff discarded used gowns in an overflowing trash receptacle in the hallway. (F Hall) Finding includes: During an observation on 10/8/20 at 12:45 P.M., LPN 6 exited room [ROOM NUMBER] on the F hall yellow zone. As LPN 6 exited the room, while they were rolling up an isolation gown with the gown against their clothing. LPN 6 then placed the gown in a trash receptacle across the hall in front of rooms [ROOM NUMBERS]. The trash receptacle was overflowing with other isolation gowns with gown material hanging out of the receptacle contacting the floor. During an interview on 10/8/20 at 1:50 P.M., CNA 14 indicated when removing PPE (Personal Protective Equipment), staff should pull isolation gown off inside out, removing gloves as the gown sleeves are removed, while keeping the used gown away from the body before disposing of it. During an interview with Infection Preventionist 2 (IP 2) on 10/8/20 at 1:55 P.M., IP 2 indicated it is best practice to remove and dispose of PPE inside of a resident's room, however, resident rooms only had small trash receptacles that filled up quickly, and that larger trash receptacles were placed in the F hall yellow zone hallway for disposal of PPE. IP2 indicated that the facility followed CDC's (Centers for Disease Control and Prevention) recommendations for doffing (taking off) PPE. During record review on 10/8/20 at 2:00 P. M, The CDC guidance for doffing PPE after caring for patients with confirmed or suspected COVID-19 included, but was not limited to, PPE must be removed slowly and deliberately in a sequence that prevents self-contamination . Remove gown. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body . During an interview on 10/8/20 at 2:10 P.M., the Facility Administrator indicated the facility did not have a policy specific to discarding PPE after caring for a resident on isolation precautions. 3.1-18(b)(2)

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.