STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155698	A. BUILDING _____ B. WING _____	**05/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHANY POINTE HEALTH CAMPUS	**1707 BETHANY RD ANDERSON, IN 46012**

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.** Based on observation and interview, the facility failed to ensure infection prevention and control protocols were followed to minimized the risk of spreading COVID-19 for 1 of 5 employees reviewed. Findings include: During a tour of the facility, on 5/18/20 beginning at 12:35 p.m., accompanied by Administrator 2, the following was observed: The Dietary Manager (DM) was seated on the side of a resident's bed assisting her with eating. The DM was wearing an isolation gown, mask, and gloves. The resident resided in area designated as an isolation unit where residents had tested positive for COVID-19. During an interview, after the DM had exited the resident's room, she indicated she had been helping the residents on the unit with lunch as part of her feeding assistant certification. Once the meal was over, she would take off her personal protective equipment, sanitize her hands, then return to the kitchen for the remainder of her shift. During a follow-up interview, on 5/18/20 at 2:37 p.m., the DM indicated she had assisted the residents in isolation related to COVID-19, on the dementia unit, with their meals on two previous occasions, once she had went home after the meal was completed, the other time she had returned to the kitchen for the remainder of her shift. A review of a current facility policy, titled Guidelines for COVID-19, dated 3/11/20 and provided by Administrator 2, on 5/18/20 at 4:38 p.m., indicated .Additional Measures for Any Scenario Noted Above. Develop a plan for isolation and/or grouping of affected residents. including dedicating employee to work only affected units 3.1-18(a)

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