STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155248	A. BUILDING _____ B. WING _____	09/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-BRENTWOOD	30 E CHANDLER AVE EVANSVILLE, IN 47713

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 transmission based precautions to prevent the spread of Covid-19 for 1 of 5 units observed. This had the potential to affect 8 of 15 residents residing on the 400 Unit that were not Covid-19 positive. (Resident 1, Resident 5, Resident 6, Resident 7, Resident 9, Resident 10, Resident 11) Finding includes: On 9/25/20 at 9:55 A.M., the 400 unit was observed with the DON. The DON indicated there were Covid-19 positive residents (Red), residents under observation for Covid-19 (yellow), and residents without transmission based precautions (green) on the unit. The DON indicated the facility was currently expanding their Covid-19 positive Red Unit to move the additional Covid-19 positive residents on that day (9/25/20). Upon observation it was unclear which rooms were under which observation. The DON indicated the facility staff informed each other during report. The DON indicated the following: room [ROOM NUMBER] (Resident 15) was considered yellow because the resident's roommate had tested positive for Covid-19. room [ROOM NUMBER] (Resident 13, Resident 14) was considered red because both residents had tested positive for Covid-19. room [ROOM NUMBER] (Resident 12) was considered yellow because the resident was readmitted from the hospital. room [ROOM NUMBER] (Resident 9, Resident 10) was considered green and two residents resided in the room. room [ROOM NUMBER] (Resident 6, Resident 7) was considered green and two residents resided in the room. room [ROOM NUMBER] (Resident 8) was considered red because the resident had tested positive. The door to the resident's room was observed to be open and a plastic barrier was only secured above the doorframe. The bottom of the plastic barrier was observed to be moving with the air flow. room [ROOM NUMBER] (Resident 1) was considered yellow. The door was observed to be open and the plastic barrier was not secured. The bottom of the plastic barrier was observed to be moving with the air flow. room [ROOM NUMBER] (Resident 4, Resident 5) was considered green and two residents resided in the room. room [ROOM NUMBER] (Resident 2, Resident 3) was considered red because the resident had tested Positive for Covid-19. At that time, the DON indicated staff only took care of residents in red rooms and the other staff members cared for the residents in green and yellow rooms. At the time of discussion LPN 1 was observed sitting at the nursing station. LPN 1 indicated she cared for all the residents on the 400 Unit. CNA 2 was also sitting at the nursing station. CNA 2 also indicated she took care of the group of residents at the front of the 400 Unit, those rooms listed above. On 9/25/20 at 10:22 A.M., the DON was indicated the following about the 400 Unit: Resident 1 in room [ROOM NUMBER] was considered a yellow room because Resident 1's roommate had tested positive for Covid-19. The resident had tested negative for Covid-19. Resident 2 and Resident 3 in room [ROOM NUMBER] had both tested positive for Covid-19 on the evening of 9/23/20. The residents were going to be moved to the extended Covid-19 Unit. Resident 4 and Resident 5 in room [ROOM NUMBER] had not tested positive for Covid-19 and were not in any isolation precautions. Resident 6 and Resident 7 in room [ROOM NUMBER] had not tested positive for Covid-19 and were not in any isolation precautions. Resident 8 in room [ROOM NUMBER] had tested positive for Covid-19 on the evening of 9/23/20. The resident was going to be moved to the expanded Covid-19 Unit. Resident 9 and Resident 10 in room [ROOM NUMBER] was considered a yellow room because both residents had recently been readmitted from the hospital. Resident 11 in room [ROOM NUMBER] was considered a yellow room because Resident 11's roommate had tested positive for Covid-19. The resident had tested negative for Covid-19. Resident 12 in room [ROOM NUMBER] had tested positive for Covid-19 on the evening of 9/23/20. The residents were going to be moved to the expanded Covid-19 Unit. Resident 13 and Resident 14 in room [ROOM NUMBER] had both tested positive for Covid-19 on the evening of 9/23/20. The residents were going to be moved to the expanded Covid-19 Unit. Resident 15 in room [ROOM NUMBER] had tested positive for Covid-19 on the evening of 9/23/20. The resident was going to be moved to the expanded Covid-19 Unit. On 9/25/20 at 12:00 P.M., the following was observed: The door to room [ROOM NUMBER] (Resident 8, red room) was observed to be open. The plastic covering over the door was only secured above the doorframe. The bottom of the plastic covering was observed to be moving with the air flow. room [ROOM NUMBER] was directly across from room [ROOM NUMBER] (Resident 6, Resident 7, green room). The door to room [ROOM NUMBER] (Resident 2, Resident 3, red room) was observed to be open. The plastic covering over the door was only secured above the doorframe. The bottom of the plastic covering was observed to moving with the air flow. The door to room [ROOM NUMBER] (Resident 9, Resident 10) was observed to be open. No plastic covering was observed to be over the door. No isolation cart or signs were posted to indicate the residents required any transmission based precautions. On 9/25/20 at 12:05 P.M., CNA 2 and LPN 1 were observed to enter room [ROOM NUMBER]. LPN 1 donned a glove, an isolation gown, and then an additional glove and then entered the room by pulling the plastic covering away from the door. On 9/25/20 at 12:15 P.M., CNA 2 indicated that Resident 9 was on isolation precautions but she was unsure what for. CNA 2 further indicated Resident 10 was not on isolation precautions. On 9/25/20 at 12:37 P.M., the Administrator indicated the Covid-19 positive residents on the 400 Unit had not been relocated to the Covid-19 Unit on 9/24/20 because the facility did not have the resources to get the additional rooms cleaned and the residents moved safely. On 9/25/20 at 12:40 P.M., the Administrator provided the facility policy for Covid-19 Infection Control. The Administrator provided the Covid-19 LTC Facility Infection Control Guidance Standard Operating Procedure dated 8/10/20. The policy included, but was not limited to: Covid-19 Positive (Red)- These are residents who are confirmed Covid-19 positive and who, based on CDC criteria, still warrant transmission based precautions. These residents should be in transmission based precautions (droplet and contact) and cohorted into a Covid-19 wing, floor, or building. 3.1-18(b)(1)

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.