STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155252	A. BUILDING _____ B. WING _____	**10/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-WOODLANDS	**4088 FRAME RD NEWBURGH, IN 47630**

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 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. (Resident 58, Resident 70, Resident 79) Findings include: 1. On 10/22/20 at 9:24 a.m., CNA 1 was observed to provide personal care to Resident 58. The resident lacked a face mask or facial covering and CNA 1 did not offer facial covering throughout the process. 2. On 10/22/20 at 9:40 a.m., CNA 3 and CMT 1 (Certified Medical Technician) were observed to provide care to Resident 70. The resident lacked a face mask or facial covering throughout the personal care and was not offered facial covering. The clinical record for Resident 70 was reviewed on 10/22/20 at 1:39 p.m. [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment, dated 8/19/20, indicated the resident had slight cognitive impairment. A care plan, indicated the resident was at risk for COVID-19 related to risk for respiratory infection. Interventions included, but was not limited to, the following: Document and report if resident had any signs and symptoms of: fever, coughing, sneezing, sore throat, respiratory issues and report promptly to my doctor, start date 8/13/20. Observe for signs/symptoms of COVID-19, start date 8/13/20. Staff to follow standard precautions, start date 8/13/20. Supply resident with a mask to wear when outside of her room as the resident tolerated, start date 8/13/20. Please educate the staff providing care, along with the resident, family and visitors of COVID-19 signs and symptoms and precautions, start date 8/13/20. Follow facility protocol for COVID-19 screening and precautions, start date 8/13/20. On 10/22/20 at 2:01 p.m., Resident 70 indicated she had never been asked to wear a mask or facial covering when she was having care provided. She had a mask which she wore when she exited her room. 3. On 10/22/20 at 11:00 a.m., CNA 1 and CNA 2 were observed to provide personal care to Resident 79. The resident lacked a face mask or facial covering and was not offered any throughout the personal care. On 10/22/20 at 11:15 a.m., CNA 1 and CNA 2 indicated they did not offer any facial coverings to the resident during personal care, only if the resident came out of their room. On 10/22/20 at 1:57 p.m., CNA 3 and CMT 1 indicated they were not aware the resident needed to wear facial covering during personal care. On 10/22/20 at 3:15 p.m., the Administrator indicated the facility lacked a policy regarding the residents wearing facial coverings during personal care. The current facility policy, 10.20.20 Guidance updates- high level, provided by the Administrator on 10/22/20 at 3:16 p.m., indicated Residents adding masks when HCP (health care personal) are < (less than) 6 feet from resident care. 3.1-18(b)

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.