STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155503	A. BUILDING _____ B. WING _____	**04/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EXCEPTIONAL LIVING CENTER OF BRAZIL	**501 S MURPHY AVE BRAZIL, IN 47834**

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 -** Many	**Provide and implement an infection prevention and control program.** Based on observation, record review, and interview, the facility failed to ensure CDC requirements were followed for the prevention of COVID 19 infection when direct care staff were not wearing face masks while working and residents on the Memory Care unit were participating in communal activities and dining. This deficiency had the potential to effect 57 of 57 residents residing in the facility. Findings include: On 4/14/20 at 9:51 a.m., during a tour of the facility with the Director of Nursing (DON), several staff were observed working on the halls with residents of the facility. Only one housekeeper was observed wearing a face mask. No other direct care staff were observed wearing a face mask. On the Memory Care unit, 7 residents were observed in the activity area participating in a communal activity. One 4-person table was observed with 4 residents sitting around the table with an unmasked staff member sitting between 2 of the residents, reading the newspaper to them. The residents were not exhibiting social distancing of at least 6 feet apart. None of the staff on the unit were observed wearing face masks. On 4/14/20 at 12:36 p.m., during an observation of the lunch meal on the Memory Care unit, 8 residents were observed in the dining area. Two 4-person tables were observed with two residents sitting directly across from each other, and one 4-person table had 2 residents sitting directly next to each other. None of the residents sitting at the 4-person tables were observed to exhibit social distancing. On 4/14/20 at 12:30 p.m., the facility's Infection Control (ICP) Manual was reviewed. Centers for Disease Control (CDC) and Indiana State Department of Health (ISDH) COVID 19 guidelines were observed. The CDC/ISDH COVID 19 Toolkit, dated 4/2/20, was not observed in the ICP manual. During an interview, on 4/14/20 at 9:26 a.m., the Administrator indicated the facility had no positive or symptomatic COVID 19 infected residents or staff. All residents were monitored each shift for symptoms, which included, but were not limited to, temperature and oxygen saturation. Staff temperatures were taken when they reported for their shifts and staff have been in-serviced to report any symptoms immediately to the charge nurse and to stay at home when they were sick. No visitors were allowed in the facility and any essential visitors (physicians, vendor, etc.), would be screened by temperature, oxygen saturation measurement, and are required to answer screening questions, prior to entry into the facility. All residents ate their meals in their rooms with the exception of the residents in the Memory Care unit. They had attempted to keep the Memory Care residents in their rooms for their meals, but many of the residents began to exhibit behavioral symptoms. During an interview, on 4/14/20 at 10:0 a.m., Licensed Practical Nurse (LPN) 3 indicated she worked the Memory Care unit regularly. She was aware that personal protective equipment (PPE) was available to all staff as was needed. She was not aware of any residents or staff that had tested positive for the COVID 19 infection, nor any that had any symptoms of the infection. Staff monitored every resident's temperature each shift and continually monitored them for other symptoms that would suggest a possible infection. The staff had attempted to stagger the residents coming into the dining area for their meals, but it had not been very successful. At the time of the interview, LPN 3 was not wearing a face mask. During an interview, on 4/14/20 at 10:09 a.m., Certified Nursing Assistant (CNA) 4 indicated she was aware that PPE was available to her as needed. Masks were kept at each nurses' station and gloves were readily available in each resident room. At the time of the interview, CNA 4 was not wearing a face mask. During an interview on 4/14/20 at 10:35 a.m., Qualified Medication Aide (QMA) 5 indicated she was aware PPE was available and that she could get it as she needed it. At the same time, Registered Nurse (RN) 6 indicated that PPE was always available to all staff. The nurses were expected to monitor all residents for signs and symptoms of infection and take their temperatures each shift. No residents were symptomatic or had any COVID 19 infection. At the time of the interview, neither QMA 5 nor RN 6 were wearing a face mask. During an interview, on 4/14/20 at 12:30 p.m., the Administrator indicated she had not seen the CDC and ISDH COVID 19 guidelines, dated 4/2/20, which required all Long Term Care (LTC) facility staff involved in direct patient care to wear a face mask during their entire shift. She had participated in a conference call with her corporate office and had been under the assumption that, since the facility had no symptomatic or COVID 19 positive residents or staff, face masks were not required. At the same time, a copy of the CDC/ISDH Toolkit, dated 4/2/20, was provided, via email, to the Administrator. The CDC guidance - Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, indicated, .Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCFs) .3. Prevent spread of COVID-19 .Cancel all group activities and communal dining Enforce social distancing among residents .Ensure all HCP wear a facemask or cloth face covering for source control while in the facility. Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required This Federal tag relates to Complaint IN 234. 3.1-18(a)(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.