STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING _____ B. WING _____	**10/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLONIAL NURSING HOME	**119 N INDIANA AVE CROWN POINT, IN 46307**

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, record review, and interview, the facility failed to ensure infection control guidelines were followed to properly prevent and/or contain COVID-19 related to personal protective equipment (PPE) not donned prior to contact with a resident on transmission based precautions during a random observation for infection control on 1 of 2 Units. (The Main Floor-Hall A) Finding includes: 1. During a random observation on 10/13/20 at 1:18 p.m., Therapy Assistant 1, entered room [ROOM NUMBER], designated as a yellow zone isolation room with the resident being on transmission based precautions. Therapy Assistant 1 was wearing goggles and a surgical mask when she repositioned the resident in bed and adjusted the resident's pillow. No gown or gloves were in use. There was an isolation sign on the door and a PPE bin in the hallway next to the door. Interview with the Director of Nursing at the time, indicated Therapy Assistant 1 should have donned a gown and gloves prior to assisting the resident. Interview with Therapy Assistant 1 on 10/13/20 at 1:45 p.m., indicated she should have donned a gown and gloves. The facility's COVID-19 policy indicated, . contact precautions including mask and other PPE as needed for 14 day monitoring . 3.1-18(a)

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.