STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. BUILDING _____ B. WING _____	**08/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCENIC HILLS AT THE MONASTERY	**710 SUNRISE DRIVE FERDINAND, IN 47532**

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 implement infection control measures to mitigate the spread of Covid 19 for 1 of 1 nursing units used for transmission based precautions. Transmission based precaution signs were not posted, doors were left open, hand sanitizer was not readily available, and hands were not washed. (QMA 1, Yellow Unit) Finding includes: On 8/5/20 at 10:30 A.M., the yellow unit was observed. 1. The Administrator indicated four residents resided on the yellow unit on transmission based precautions. Three of the doors to the residents rooms were observed to be open. At that time, the Administrator indicated the doors should be closed. 2. room [ROOM NUMBER] lacked a sign on the door to indicate what type of transmission based precautions were needed. room [ROOM NUMBER] had a droplet precaution sign posted. The contact precaution sign was located on top of the isolation cart. 3. At 10:32 A.M., QMA 1 was observed to donn PPE to enter room [ROOM NUMBER]. Upon exiting the room, QMA 1 placed a bag of trash on the floor, opened the top drawer to the isolation cart, touching clean PPE and other contents in the drawer before she obtained a bottle of hand sanitizer. QMA 1 performed hand hygiene with the alcohol based rub. QMA 1 picked up the bag of trash and safety glasses and exited the yellow zone into the dirty utility closet outside of the unit. QMA 1 cleaned her safety glasses and washed her hands under running water. On 8/5/20 at 12:23 P.M., LPN 1 indicated the facility policy was to wash their hands for 20 seconds. LPN 1 indicated they should wet their hands, add soap, and rub their hands vigorously for 20 seconds. On 8/5/20 at 12:26 P.M., the Administrator provided the current Guideline for Handwashing/Hand Hygiene policy. At that time, the policy was reviewed and included, but was not limited to: Wash well for 20 seconds, using a rotary motion and friction. Rinse hands well under running water 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.