STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155138	A. BUILDING _____ B. WING _____	10/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-INDIANAPOLIS	2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203

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 ensure signage was posted at the entrance to the yellow zone, a dedicated area of the facility which housed individuals who were under droplet isolation precautions due to COVID-19, for 7 of 7 residents that resided on 1 of 1 yellow unit reviewed for COVID-19 infection control. (Residents 90, 91, 92, 94, 81, 80, and 88) Findings include: During a facility tour, on 10/19/20 at 10:00 a.m., observed the yellow zone, a dedicated area of the facility which housed individuals who were under droplet isolation precautions due to COVID-19. The entrance into the yellow zone lacked signage that indicated COVID-19 isolation precautionary measures were to occur. The following 7 residents were identified as residing in the facility's yellow zone. 1. On 10/19/20 at 10:00 a.m., observed Resident 90's room door to be closed. The door contained a sign directing staff what PPE (personal protective equipment) must be worn; what precautions to take; type of isolation; and who to direct questions to for a resident in isolation precaution status. On 10/19/20 at 10:30 a.m., Resident 90's clinical record was reviewed. [DIAGNOSES REDACTED]. Interview, on 10/19/20 at 4:00 p.m., the Director of Nursing (DON) indicated Resident 90 was on droplet isolation precautions as a COVID-19 precautionary measure. Resident 90 had left the facility for [MEDICAL TREATMENT] services and will remain in the yellow zone on isolation precautions. The DON indicated the entrance into the yellow zone lacked any signage regarding the status of the isolation precautions required for residents who resided within that unit. 2. On 10/19/20, at 10:05 a.m., observed Resident 91's room door to be closed. The door contained a sign directing staff what PPE (personal protective equipment) must be worn; what precautions to take; type of isolation; and who to direct questions to for a resident in isolation precaution status. On 10/19/20 at 10:35 a.m., Resident 91's clinical record was reviewed. Resident 91 was admitted to the yellow zone on 10/11/20, as a precautionary measure. Interview, on 10/19/20 at 4:00 p.m., the Director of Nursing (DON) indicated Resident 91 was on droplet isolation precautions as a COVID-19 precautionary measure. Resident 91 was a new admission and was required to be in the yellow zone as a COVID-19 precautionary measure. The DON indicated the entrance into the yellow zone lacked any signage regarding the status of the isolation precautions required for residents who resided within that unit. 3. On 10/19/20 at 10:10 a.m., observed Resident 92's room door to be closed. The door contained a sign directing staff what PPE (personal protective equipment) must be worn; what precautions to take; type of isolation; and who to direct questions to for a resident in isolation precaution status. On 10/19/20 at 10:35 a.m., Resident 92's clinical record was reviewed. Resident 91 was a new admit to the facility and was admitted to the yellow zone on 10/14/20, as a precautionary measure. Interview, on 10/19/20 at 4:00 p.m., the Director of Nursing (DON) indicated Resident 92 was on droplet isolation precautions as a COVID-19 precautionary measure. Resident 92 was a new admission and was required to be in the yellow zone as a COVID-19 precautionary measure. The DON indicated the entrance into the yellow zone lacked any signage regarding the status of the isolation precautions required for residents who resided within that unit. 4. On 10/19/20 at 10:15 a.m., observed Resident 94's room door to be closed. The door contained a sign directing staff what PPE (personal protective equipment) must be worn; what precautions to take; type of isolation; and who to direct questions to for a resident in isolation precaution status. On 10/19/20 at 10:40 a.m., Resident 94's clinical record was reviewed. Resident 94 was a new admit to the facility and was admitted to the yellow zone on 10/9/20, as a precautionary measure. Interview, on 10/19/20 at 4:00 p.m., the Director of Nursing (DON) indicated Resident 94 was on droplet isolation precautions as a COVID-19 precautionary measure. Resident 94 was a new admission and was required to be in the yellow zone as a COVID-19 precautionary measure. The DON indicated the entrance into the yellow zone lacked any signage regarding the status of the isolation precautions required for residents who resided within that unit. 5. On 10/19/20 at 10:20 a.m., observed Resident 81's room door to be closed. The door contained a sign directing staff what PPE (personal protective equipment) must be worn; what precautions to take; type of isolation; and who to direct questions to for a resident in isolation precaution status. On 10/19/20 at 10:40 a.m., Resident 81's clinical record was reviewed. Resident 81 was readmitted to the facility from another facility and was admitted into yellow zone on 10/16/20, as a precautionary measure. Interview, on 10/19/20 at 4:00 p.m., the Director of Nursing (DON) indicated Resident 81 was on droplet isolation precautions as a COVID-19 precautionary measure. Resident 81 was a re-admission and was required to be in the yellow zone as a COVID-19 precautionary measure. The DON indicated the entrance into the yellow zone lacked any signage regarding the status of the isolation precautions required for residents who resided within that unit. 6. On 10/19/20 at 10:25 a.m., observed Resident 80's room door to be closed. The door contained a sign directing staff what PPE (personal protective equipment) must be worn; what precautions to take; type of isolation; and who to direct questions to for a resident in isolation precaution status. On 10/19/20 at 10:45 a.m., Resident 80's clinical record was reviewed. [DIAGNOSES REDACTED]. Interview, on 10/19/20 at 4:00 p.m., the Director of Nursing (DON) indicated Resident 80 was on droplet isolation precautions as a COVID-19 precautionary measure. Resident 80 had left the facility for [MEDICAL TREATMENT] services and will remain in isolation. The DON indicated the entrance into the yellow zone lacked any signage regarding the status of the isolation precautions required for residents who resided within that unit. 7. On 10/19/20, at 10:30 a.m., observed Resident 88's room door to be closed. The door contained a sign directing staff what PPE (personal protective equipment) must be worn; what precautions to take; type of isolation; and who to direct questions to for a resident in isolation precaution status. On 10/19/20 at 10:50 a.m., Resident 88's clinical record was reviewed. [DIAGNOSES REDACTED]. Interview, on 10/19/20 at 4:00 p.m., the Director of Nursing (DON) indicated Resident 88 was on droplet isolation precautions as a COVID-19 precautionary measure. Resident 88 had left the facility for [MEDICAL TREATMENT] services and will remain in isolation. The DON indicated the entrance into the yellow zone lacked any signage regarding the status of the isolation precautions required for residents who resided within that unit. On 10/19/20 at 10:00 a.m., the Administrator provided a policy titled Isolation Precautions, dated 9/15/20, and indicated it was the current policy being used by the facility. A review of the policy indicated, .It is our policy to take appropriate precautions, including isolation, to prevent transmission of infectious agents. This policy specifies the different types of precautions, including when and how isolation should be used for a resident .information regarding the particular type of precaution to be utilized will be communicated through verbal reports, written in-house communication forms, and signage . On 10/19/20 at 10:00 a.m., the Administrator provided a policy titled COVID-19 LTC (long term care) Facility Infection Control Guidance Standard Operating Procedure, dated 7/23/20, and indicated it was the current policy being used by the facility. A review of the policy indicated, .All LTC (long term care) facilities should have a plan to rapidly implement, or implement now, how they will cohort confirmed or presumed COVID-19 patients in their facilities. This can be by wing, floor .Patients should be cohorted depending on COVID-19 wing, floor or building. Colors can be used on facility maps to help visualize testing results to facilitate moving of residents .Unknown COVID-19 status (yellow): All residents in this category warrant transmission based precautions (droplet and contact) .place a sign on the door indicating droplet-contact precautions . On 10/19/20 at 3:55 p.m., a review of the CDC (Center for Disease Control, isolation guidelines, located at https://www.cdc/gov/infectioncontrol/pdf/droplet precautions-signP.pdf indicated, .signage .is important to ensuring all

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) staff are aware of the necessary infection control steps . 3.1-18(b)