STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155815	A. BUILDING _____ B. WING _____	**06/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLEARVISTA LAKE HEALTH CAMPUS	**8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256**

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 utilized personal protective equipment (PPE) during care for residents who were in observation for Covid-19 and to ensure staff donned PPE while in a residents room that was being monitored in droplet isolation for 4 of 4 residents reviewed for infection control (Resident 14, 17, 32, and 33) Findings include: 1. The clinical record for Resident 14 was reviewed on 6/10/2020 at 12:10 p.m. The resident's [DIAGNOSES REDACTED]. She was admitted to the facilities yellow unit on 6/8/2020. 2. The clinical record for Resident 17 was reviewed on 6/10/20 at 11:50 a.m. The resident's [DIAGNOSES REDACTED]. He was admitted to the facilities yellow unit on 6/4/2020. The clinical record for Resident 14 contained a physician's orders [REDACTED]. (Quarantine) Resident stayed in room entire shift with NO ROOMMATE. All therapy, meals, activities and services were provided in the room . The clinical record for Resident 17 contained a physician's orders [REDACTED]. (Quarantine) Resident stayed in room entire shift with NO ROOMMATE. All therapy, meals, activities and services were provided in the room . On 6/10/20 at 12:30 p.m., Resident 14 was observed sitting in her wheel chair in her room. There was no PPE (Personal Protective Equipment) available at the entrance of her room and no sign indicating that PPE should be used when caring for her. On 6/10/2020 at 12:31 p.m., Resident 17 was observed laying in his bed in his room. There was no PPE available at the entrance of her room and no sign indicating that PPE should be used when caring for him. On 6/10/2020 at 12:50 p.m., Resident 14 was observed sitting in her wheel chair in her room speaking with PT (Physical Therapist) 1. He was sitting in a chair in her room and had a mask on while speaking to her. He was not wearing an isolation gown. 3. The clinical record for Resident 33 was reviewed on 6/10/20 at 12:30 p.m. The [DIAGNOSES REDACTED]. Resident 33 was admitted on [DATE] and placed in the yellow unit. A physician order [REDACTED]. .Resident stayed in room entire shift with no roommate. All therapy, meals, activities and services were provided in the room . A nursing progress note dated 6/4/20 indicated Resident 33 had been sent to the emergency room due to coffee ground emesis and decreased oxygen saturation. An observation was made of Resident 33 on 6/10/20 at 12:23 p.m. There was no observation of PPE cart in the hallway outside of the door. An interview was conducted with Staff Development Coordinator (SDC) and License Practical Nurse (LPN) 3 on 6/10/20 at 1:23 p.m. The SDC and LPN 3 indicated Residents 14, 17 and 33 was on the yellow unit. The residents on this unit are being observed for Covid- 19 symptoms due to being in the hospital and having the possibility of exposure. They all have had negative Covid tests prior to being admitted . We only use masks for them. They had not been instructed to use any other PPE while caring for them. On 6/10/2020 at 11:54 a.m., the Clinical Support Nurse provided the Covid-19 Emergency Operational Plan Checklist, updated 4/15/2020, which indicated to follow current CDC, CMS, and/ or state screening recommendations. Responding to Coronavirus (Covid-19) in Nursing Homes from the CDC at www.cdc.gov dated 4/30/20, was retrieved on 6/10/20. It indicated .Considerations for new admissions or readmissions to the facility .Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE . 4. The clinical record for Resident 32 was reviewed on 6/10/20 at 12:00 p.m. The [DIAGNOSES REDACTED]. Resident 32 was admitted on [DATE] and placed in the yellow unit. A physician order [REDACTED]. .Resident stayed in room entire shift with no roommate. All therapy, meals, activities and services were provided in the room . A physician order [REDACTED]. An observation was made of Resident 32 on 6/10/20 at 1:34 p.m. Resident 32's room was observed in the hallway with a droplet isolation sign on the wall and a cart containing PPE was sitting by the doorway. Certified Resident Care Assistant (CRCA) 5 was observed entering the room and wearing only a mask prior to entering the room. She had not donned on any other PPE prior to entrance. During that time, CRCA 5 was observed at the resident's bedside speaking with the resident. An interview was conducted with Clinical Support 1 and CRCA 5 on 6/10/20 at 1:52 p.m. CRCA 5 indicated she had not donned on PPE prior to entering Resident 32's room, because she was just dropping off a drink to the resident. She didn't think she had to wear any. Clinical Support 1 indicated CRCA 5 should have had PPE on in the resident's room. 31-18(a)

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