STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155042	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOW MANOR	**3801 OLD BRUCEVILLE ROAD, BOX 136 VINCENNES, IN 47591**

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 -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to ensure infection prevention policies and procedures were implemented to mitigate the spread of Covid-19 for 2 of 4 nursing units observed. Face masks were not worn properly, nebulizer treatments were administered without infection control measures implemented, PPE (personal protective equipment) was not donned properly, and residents on transmission based precautions doors were not closed. (G/H/I Unit, E/F Unit, CNA 3, CNA 4, CNA 5, Resident J, Resident K, Resident M, Resident G, Resident H, Resident E, Resident F) Findings include: 1. On 7/15/20 at 9:50 A.M., during a tour of the G/H/I Unit the following was observed with UM (Unit Manager) 1. a. An isolation cart was observed outside of Resident E's room. A sign was posted that indicated to see the nurse before entering the room. UM 1 indicated Resident E was on transmission based precautions related to a readmission from the hospital. Resident E's room door was observed to be open. b. An isolation cart was observed outside of Resident F's room. A sign was posted that indicated to see the nurse before entering the room. UM 1 indicated Resident F as on transmission based precautions related to leaving the facility for appointments. Resident F's room door was observed to be open and Resident F was observed to be sitting in the doorway. Resident F was not observed to be wearing a face mask. 2. On 7/15/20 at 10:11 A.M., during a tour of the E/F Unit the following was observed with UM 2. a. Resident G and Resident H were observed to be roommates. Resident G and Resident H were both sitting in their room. Resident G was observed to be receiving a nebulizer treatment. Resident H was not observed to be wearing a facemask. On 7/15/20 at 10:19 A.M., UM 6 indicated facility was trying not to have nebulizer treatments ordered. UM 6 indicated if a resident did have a nebulizer treatment ordered, the door should be closed, a window should be open, and the resident should not have a roommate in the room. On 7/16/20 at 1:33 P.M., the Administrator, DON, and UM 6 indicated if a resident had a nebulizer treatment, the door should be shut, the window should be open, and the roommate should be out of the room. 3. On 7/16/20 at 1:55 P.M., CNA 3 was observed to be wearing her face mask around her neck while standing at the E/F Unit nursing station talking to other staff members. 4. On 7/16/20 1:57 P.M., the following was observed during a tour of the G/H/I Unit. a. CNA 4 was observed to be wearing a face mask that did not cover her nose while standing at the G/H/I Unit nursing station. b. An isolation cart was observed to be outside of Resident J's room. A sign was posted that indicated to see the nurse before entering the room. The door to Resident J's room was observed to be open. c. An isolation cart was observed to be outside of Resident K's room. A sign was posted that indicated to see the nurse before entering the room. The door to Resident K's room was observed to be open. 5. On 7/16/20 at 2:00 P.M., CNA 3 was observed to be preparing to enter Resident M's room. An isolation cart was observed outside of Resident M's room. CNA 3 indicated she believed Resident M was on transmission based precautions related to a readmission from the hospital. CNA 3 donned gloves, obtained an isolation gown from the isolation cart, shook the gown, removed the gloves, and donned the isolation gown. No hand hygiene was observed. CNA 3 donned a clean pair of gloves, obtained a face shield from the isolation cart, and donned the face shield. CNA 3 entered the room. As CNA 3 entered the room, CNA 5 was observed to be in the room without a face shield. At that time, UM 2 indicated Resident M was on transmission based precautions related to a return from the hospital. On 7/16/20 at 2:14 P.M., the DON indicated facility administration completed observational rounds of the unit to ensure face masks were worn correctly and PPE (personal protective equipment) was donned and doffed properly. On 7/16/20 at 2:17 P.M., the DON provided the current COVID-19 Personal Protective Equipment: Donning policy. The policy included, but was not limited to: Step 1: Perform Hand Hygiene Step 2: Don Gown Step 3: Don N95 Respirator Step 4: Don Face Shield and/or Goggles Step 5: Don Gloves 3.1-18(b)(1)

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