STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155070	A. BUILDING _____ B. WING _____	**07/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREEN VALLEY CARE CENTER	**3118 GREEN VALLEY RD NEW ALBANY, IN 47150**

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.** Based on observation and interview, the facility failed to follow infection control guidelines related to Covid-19 for appropriate mask usage for 2 of 36 staff observed. (CNA 2 and DON) Findings include: During an observation, on 7/27/20 at 10:35 a.m., CNA (Certified Nursing Assistant) 2, with her mask under her nose, covering her mouth and chin only. The CNA was standing at the nurses' station speaking with CNA 3. The two CNAs were within three feet from each other. An interview, on 7/27/20 at 10:36 a.m., CNA 2 indicated the facility policy/infection prevention was to ensure the mask covered the nose and mouth. During an observation and interview, on 7/27/20 at 12:45 p.m., the DON (Director of Nursing) entered the conference room with her mask below her nose, she then pulled the mask under her chin to talk. The DON indicated the facility policy/infection prevention was for the mask to cover the nose and mouth. The current facility policy titled Personal Protective Equipment and dated 3/23/20, was provided by the DON on 7/27/20 at 2:05 p.m. The policy indicated, .Purpose to reduce the risk of and prevent the spread of infection to patients, visitors, and staff .Procedure .Donning (putting on) PPE .4. Put on facemask .b. For facemask: .i. Facemask should be extended under chin. Both mouth and nose should be protected. 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.