STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155157	A. BUILDING _____ B. WING _____	**04/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-RICHMOND	**1042 OAK DR RICHMOND, IN 47374**

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 -** Many	**Provide and implement an infection prevention and control program.** Based on record review and interview, the facility failed to prevent and limit exposure of staff and residents to COVID-19 by not monitoring residents for signs and symptoms of COVID-19 which had the potential to effect 65 of 65 residents residing in the facility. The facility failed to ensure residents were not exposed to COVID-19 by moving 5 potentially exposed residents into rooms of 5 potentially unexposed residents. Findings include: 1. Resident B's clinical record was reviewed on 4/24/20. Resident B's temperature was taken and recorded on 3/26/20, 3/27/20, 4/4/20 and 4/10/20. His temperatures were not being monitored daily per Centers for Disease Control (CDC) guidance issued on 3/15/20. A change in condition note written on 4/18/2020 at 5:59 p.m., indicated, Resident B was complaining of chest pain upon touching, didn't feel right and said he felt weak and shaky. His vital signs taken at that time were: blood pressure 124/70, heart rate of 61, temperature of 101.4 and oxygen saturation of 95% on room air. His physician was called and ordered for the resident to be sent to the Emergency Department. An interview with AVP (Area Vice President) on 4/24/20 at 1:21 p.m. indicated, Resident B had developed a fever of 101.7 on 4/18/20, and was sent to the hospital where he was tested for COVID-19. The result of that swab was negative for COVID-19 but, he was positive for pneumonia and was admitted to hospital. On 4/19/20, the hospital tested the resident again for COVID-19. The final result came back on 4/22/20 and the result this time was positive for COVID-19. The facility was notified on 4/22/20 of the positive result per AVP. Resident C's clinical record was reviewed on 4/24/20. Resident C's temperature were taken on 3/26/20, 3/27/20, 4/4/20, 4/10/20, and 4/22/20. Her temperatures were not being monitored daily. Resident D's clinical record was reviewed on 4/24/20. Resident D's temperatures were taken on 3/26/20, 3/27/20, 4/4/20, 4/9/20, 4/10/20, and 4/13/20. Her temperatures were not being monitored daily. An interview with IP (Infection Preventionist) on 4/24/20 at 2:41 p.m. indicated, after finding out that Resident B was positive for COVID-19 on 4/22/20, the facility instituted a COVID-19 assessment form to monitor all residents for signs/symptoms of COVID. This assessment monitored: temperature, respirations, oxygen saturation, malaise/fatigue, sore throat, cough, shortness of breath, nausea, vomiting, diarrhea, and muscle aches. An interview with IP was conducted on 4/24/20 at 4:04 p.m. She indicated the facility's Medical Director had written a facility wide order to monitor all residents' temperatures and oxygen saturations for 7 days back around March 21, 2020. The facility monitored and recorded residents' temperatures for those 7 days then stopped taking all residents' temperatures daily until as of recently. She was unaware of the CDC guidance that came out on 3/15 indicating that all residents and staff are to be monitored at least daily for signs/symptoms of COVID-19. The CDC guidance issued on 3/15/20, indicated to, Ask residents to report if they feel feverish or have symptoms consistent with COVID-19. Actively monitor all residents upon admission and at least daily for fever (Temperature >100.0 F) and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches). If positive for fever or symptoms, implement Transmission-Based Precautions as described below. Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 The Indiana State Department of Health issued a COVID-19 Infection Prevention toolkit to all facilities on 3/24/20 which contained a CDC COVID-19 preparation checklist for facilities. The checklist indicated, the facility was to have a process to identify and manage residents with symptoms of respiratory infection (e.g., cough, fever, sore throat) upon admission and daily during their stay at the facility as well as, to have criteria and protocol for initiating active surveillance for respiratory infection among residents and healthcare personnel. 2. Resident B's clinical record was reviewed on 4/24/20. A change in condition note written on 4/18/2020 at 5:59 p.m., indicated, Resident B was complaining of chest pain upon touching, didn't feel right and said he felt weak and shaky. His vital signs taken at that time were: blood pressure 124/70, heart rate of 61, temperature of 101.4 and oxygen saturation of 95% on room air. His physician was called and ordered for the resident to be sent to the Emergency Department. The facility was informed of Resident B's positive COVID-19 status on 4/22/20 per an interview with the AVP (Area Vice President) on 4/24/20. An observation was made on 4/24/20 at 12:47 p.m., of Resident B's room. It was located on a small hallway along with 6 additional rooms. On 4/23/20, the facility moved the residents from their rooms on that hallway and relocated the residents. Five of those residents were moved into rooms on a different hall with a roommate. An interview with IP (Infection Preventionist) on 4/24/20 at 4:04 p.m., indicated, the residents were moved from their rooms, which were in the same hallway as Resident B's room, as a measure to quickly form an isolation unit and that some residents were moved into rooms with roommates. An interview with AVP on 4/24/20 at 4:04 p.m., indicated, the decision was made to move the residents off that hallway to create the isolation unit. He did not think the residents were persons under investigation for COVID-19 because Resident B was initially negative for COVID-19 on 4/18/20 and probably got COVID-19 at the hospital when admitted for pneumonia. The facility did not recognize that the same staff that cared for Resident B prior to be admitted to the hospital had also cared for the other residents on that hallway. None of those rooms were under contact precautions so gowns and gloves were not required for entry to those rooms and all residents cared for by those staff members might have been potentially exposed to COVID-19 during Resident B's stay at the facility. As a result of moving the potentially exposed residents to another hallway, the facility had potentially exposed residents who were potentially unexposed prior to getting a roommate. The CDC guidance - Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, indicated, Dedicate Space in the Facility to Monitor and Care for Residents with COVID-19 .Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive). Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them The ISDH Guidance for out-of-hospital facilities, dated 3/29/20, indicated, .Patients with close contact with a confirmed COVID-19 patient (e.g., roommate or infected staff without wearing PPE) should be isolated and follow 14 day self-monitoring guidelines. If they develop symptoms, and are confirmed or suspected to have COVID-19, they should remain isolation until at least 7 days after symptom onset and 72 hours after resolution of fever, without use of antipyretic medication, and improvement in symptoms (e.g., cough), whichever is longer . This Federal Tag relates to Complaint IN 660. 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.