STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING _____ B. WING _____	**10/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST RIVER HEALTH CAMPUS	**714 S EICKHOFF RD EVANSVILLE, IN 47712**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program during the COVID-19 crisis for 6 of 9 residents observed. Residents were not provided facial coverings during personal care, residents were observed in the hall with no facial coverings on and not social distancing, hand hygiene was not performed while providing resident care, and staff masks and face shields were stored outside of paper bags in the hall and the paper bags were open. (Resident 5, Resident 8, Resident 6, Resident 32, Resident 23, Resident 31) Findings include: 1. On 10/2/20 at 10:43 a.m., Resident 5 was observed propelling himself down the hall. His face mask was observed below his nose. Two staff members were observed in the hall. 2. On 10/2/20 at 10:47 a.m., four residents were observed on the 200 unit lounge with no masks on. Three residents were observed seated across from the nurse's station on the 200 unit with no masks on. The residents were not social distancing. Two staff members were observed sitting at the nurse's station and offered no masks to any of the residents. 3. On 10/2/20 at 10:58 a.m., the staff masks and face shields were observed sitting in the hall between the skilled unit and residential unit. Four paper bags with masks and shields were open and one used mask was observed lying in a cubicle and not in a paper bag, 4. On 10/2/20 at 11:02 a.m., CNA 1 and CNA 2 were observed to provide personal care to Resident 8. CNA 1 was observed to enter the resident's room and apply gloves. No hand hygiene was observed. CNA 1 lowered the resident's head of the bed and obtained a clean brief and washcloths. After applying periwash to the cloths, CNA 1 washed the resident's bilateral groins and perineum. CNA 1 changed her gloves and performed hand hygiene. The resident did not wear a face mask or facial covering, nor was the resident offered any facial covering throughout the personal care. On 10/2/20 at 11:19 a.m., CNA 1 indicated she should have performed hand hygiene prior to donning her gloves. Hand hygiene should be performed prior to donning gloves, before resident care, after washing an area of the resident's body, and after removing gloves. CNA 1 indicated facial coverings or masks were not offered to the residents prior to care, only if they were out of their room. CNA 1 indicated staff masks and face shields were placed in paper bags for reuse and placed in the cubicles in the hall between the skilled and residential units. The paper bags should be closed. The masks were changed out weekly and the face shields were changed out every 1-2 weeks. 5. During an observation on 10/2/20 at 11:15 a.m., Resident 6 was observed in his Broda chair in the 200 hall. Resident 6 was not socially distanced from other residents and was not wearing a mask. Staff member was observed in the hall, and no redirection or education was observed. During a review of Resident 6's clinical record on 10/2/20 at 9:45 a.m., it indicated Resident 6 was severely cognitively impaired. Resident 6's [DIAGNOSES REDACTED]. Resident 6's care plans included, but were not limited to, Resident demonstrates non-compliance with physician orders [REDACTED]. Cognitive impairment. Interventions included, but were not limited to, staff will reapproach as appropriate to aid and assist resident in following the policy and procedures as related to Covid-19 while respecting their wishes. Start date, 5/22/20, revised on 7/16/20. 6. During an observation on 10/2/20 at 11:18 a.m., Resident 32 was observed in the 200 hall sitting next to the window near the nurses' station. Resident 32 was not wearing a mask. Staff was observed in the hall, and no redirection or education was observed. During a review of Resident 32's clinical record on 10/2/20 at 12:25 p.m., it indicated Resident 32 was severely cognitively impaired. Resident 32's [DIAGNOSES REDACTED]. Resident 32's care plans included, but were not limited to, Resident demonstrates non-compliance with physician orders [REDACTED]. Cognitive impairment. Interventions included, but were not limited to, staff will reapproach as appropriate to aid and assist resident in following the policy and procedures as related to Covid-19 while respecting their wishes. Start date, 5/22/20, revised 8/20/20. 7. During an observation on 10/2/20 at 11:18 a.m., Resident 23 was observed in the 200 hall, not socially distanced from other residents, and not wearing a mask. Staff was observed in the 200 hall, but no redirection or education was observed. During a review of Resident 23's clinical record on 10/2/20 at 12:40 p.m., it indicated Resident 23 was severely cognitively impaired. Resident 23's [DIAGNOSES REDACTED]. Resident 23's care plans included, but were not limited to, Resident demonstrates non-compliance with physician orders [REDACTED]. Resident has cognitive impairment. Interventions included, but were not limited to, staff will approach and reapproach resident to help assist and aid resident in following the Covid-19 policy and procedures while respecting resident's wishes. Start date, 5/22/20, revised 8/29/20. 8. During an observation on 10/2/20 at 11:18 a.m., Resident 31 was observed sitting in the 200 hall. Resident 31 was not socially distanced from other residents and was not wearing a mask. Staff was observed in the 200 hall, but no redirection or education was observed. During a review of Resident 31's clinical record on 10/2/20 at 12:17 p.m., it indicated Resident 31 was severely cognitively impaired. Resident 31's [DIAGNOSES REDACTED]. Resident 31's care plans included, but were not limited to, Resident demonstrates non-compliance with physician orders [REDACTED]. Resident has [DIAGNOSES REDACTED]. Start date 10/2/20. During an interview on 10/2/20 at 11:20 a.m., Activity Assistant 1 indicated most residents on the hall were care planned for not wearing a mask. Activity Assistant 1 said, they eat them. Indicated staff is supposed to try to remind and redirect when they can. During an interview on 10/2/20 at 12:35 p.m., the Regional Nurse Consultant, she indicated residents should be spread out and socially distanced, and staff should be attempting mask use. It is hard with this population, but attempts by staff should be made to redirect and remind on mask use and social distancing. The current facility policy, Guidelines for Handwashing/Hand Hygiene, dated 5/11/16, revised 3/12/20, provided by the Regional Nurse Consultant on 10/2/20 at 1:45 p.m., included, but was not limited to, Health Care Workers shall use hand hygiene at times such as: . Before/after having direct physical contact with residents. The current facility policy, Guidelines for COVID-19, dated 3/11/20, provided by the Regional Nurse Consultant on 10/2/20 at 1:45 p.m., included but was not limited to, When social distancing is not possible, encourage resident(s) to wear face mask. 3.1-18(b) 3.1-18(l)

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