STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING _____ B. WING _____	**04/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF NEWBURGH	**5233 ROSEBUD LANE NEWBURGH, IN 47630**

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 maintain an infection prevention and control program during the COVID 19 crisis. The dedicated COVID-19 unit barrier was observed unzipped and open, staff was observed coming from the dedicated COVID-19 unit onto the regular unit to wash up and change clothes at the end of the shift, and resident's charts were located on the COVID-19 unit for residents on the regular unit. This had the potential to affect 44 residents in the facility. Findings include: On 4/16/2020 at 4:10 a.m. RN 1 was observed in the hall on the regular skilled unit. RN 1 indicated she was working on the dedicated COVID unit, but she was the only nurse on staff for the night. She indicated staff on the dedicated COVID unit entered and exited through the COVID-19 unit doors and should not be coming onto the regular skilled part of the facility. She indicated she had to come to the regular skilled unit earlier to obtain a blood specimen from Resident C for the laboratory to take to the laboratory. When laboratory specimens were obtained, they were placed into a red laboratory plastic bag and either the laboratory personnel would take the specimen or the specimen would be placed into a refrigerator or the laboratory bin. The resident's laboratory specimen should never be taken from the regular skilled unit onto the dedicated COVID-19 unit or vice versa. The laboratory staff would double bag the specimens when they obtained the specimens, but it was not the policy of the facility to double bag the specimens. On 4/16/2020 at 6:31 a.m., the first plastic barrier from the regular skilled unit to the dedicated COVID-19 unit was observed to be unzipped and partially opened. QMA 1 was observed to walk up the hall, enter the barrier clean area and zip the barrier shut after entering the barrier area. On 4/16/2020 at 6:45 a.m., RN 1 was observed to exit the dedicated COVID-19 unit into the regular skilled unit. RN 1 indicated she was going home. She was unable to go out through the dedicated COVID-19 exit door as the room to clean up and change her clothes did not have a lock on the door. She indicated the other staff members who had worked with her on the dedicated COVID-19 unit had exited through the designated COVID-19 unit door after cleaning themselves, obtaining their temperatures, and doing their assessments. She indicated she worked in management and was going to clean up and change her clothes in the bathroom close to the front lobby, prior to obtaining her temperature, doing her own assessment, and exiting the front lobby door. On 4/16/2020 at 7:49 a.m., LPN 1 indicated RN 1 had cross-contaminated when she came from the COVID-19 unit to the regular unit to change her clothes and clean up prior to leaving the building. The facility normally has 2 nurses on the night shift, one for the dedicated COVID-19 unit and one for the regular skilled unit. One of the usual night nurses had been off work for a while and the facility had been using agency staff. LPN 1 indicated the hard charts contained the laboratory results in them but the regular skilled 200 hall resident's charts were located on the COVID-19 unit at this time. If the facility obtained a laboratory result, the unit manager on the dedicated COVID-19 unit would notify the physician of those results. Laboratory specimens should never be taken from one unit to another. The hospital laboratory personnel would bring their own bags for double bagging the specimens but the facility did not double bag the specimens. The specimens were either refrigerated or placed into a bin for the laboratory staff to pick up. The facility tried to schedule all the routine laboratory tests for Mondays but the laboratory staff would obtain the specimens whenever they were needed. On 4/16/2020 at 11:05 a.m., the Administrator indicated the facility had an entrance and exit for the dedicated COVID unit in which the employees were to use for entering and exiting. The facility was not aware the lock on the changing room was broken. They realized they had only 1 nurse on the night shift and there should be 2. They had recently hired a new night shift nurse and had been using agency staffing to assist with their staffing needs. The facility recognized the hard charts for the non-dedicated facility residents on the 200 hall were left on the dedicated COVID-19 unit. The current facility policy, Novel Coronavirus (COVID-19), effective date 3/10/2020, last revised 3/19/2020, obtained from the Staff Development Coordinator, on 4/16/2020 at 10:10 a.m., included, but was not limited to, The purpose of this guideline is to provide clarification for steps the facility will take regarding the novel Coronavirus (COVID-19) and ensure the health and safety of the facility's resident to meet the standards required to help each resident attain or maintain their highest level of well-being. Considering the recent spread of COVID-19, our Organization will attempt to minimize exposures to respiratory pathogens and promptly identify residents/patients with clinical features and risk for COVID-19. Where possible, staff who were assigned to affected units will not work unaffected units. This Federal tag relates to Complaint IN 656. 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.