STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155278	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-BLOOMINGTON	**155 E BURKS DR BLOOMINGTON, IN 47401**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure: 1. Hand hygiene was performed for all residents prior to dining, this had the potential to affect 104 of 104 residents at the time of the survey. 2. Face masks were properly secured while being worn for two of two nurses. 3. The plastic sheeting to the Covid-19 Unit was not attached to the ceiling to provide an airtight barrier for two of two residents residing in the Unit. 4. Soiled items were placed with clean items on the drinking cart in one of two units 5. Disposable gowns were not being properly disposed of following use in the Covid-19 Unit. This had the potential to affect two of two residents residing in the Unit at the time of the observation. Findings include: 1. Observation with the Director of Nursing (DON) on all nursing units during the evening meal on with 7/6/20 at 5:10pm, revealed hand hygiene was not performed on residents prior to the meal time. Observation revealed that the Certified Nursing Assistants (NA) went from room to room, delivered the trays to the residents and exited the rooms. When the DON was questioned about hand hygiene for residents, the DON stated we don't wash their hands before all meals, unless they are soiled and then we would wash them. When asked about a policy and procedure regarding hand hygiene for residents, the DON stated no we don't have one.According to F880 related to hand hygiene indicated If residents need assistance with hand hygiene, staff should assist with washing hands before meals . 2. Observation with the DON during the delivery of the evening meal on 7/6/20 at approximately 5:30pm, at the Station One Unit revealed that a soiled drinking glass, fork and spoon were placed next to the clean drinking glasses and juice pitchers on the top shelf of the delivery cart. During an interview with the DON about the observation, the DON stated they should not have put the soiled items next to the clean items. 3. Observation during the delivery of the evening meal on 7/6/20 at approximately 5:40pm, at the Station One Unit, revealed that discarded paper products from straws and napkins were noted on the top three tier shelf of a cart. The soiled items were noted next to the clean juice and water pitchers stored on the cart in Station One Unit hall. The DON who accompanied the surveyor at the time of the observation stated those things should have been thrown away and not put on the clean cart. 4. Observation with the DON during the general tour of the units on 7/6/20 at approximately 6pm, revealed that all staff in the facility were required to wear N95 masks. Observation revealed that the Unit Manager in the Alzheimer's Care Unit was noted to have a N95 in place, however it was not securely attached to her face. One strap of the N95 was hanging off of the mask and not securely attached to the back of her head. The DON noted the observation and stated both straps should have been used to secure the N95 mask. 5. Observation during the same tour of the units on 7/6/20 revealed that LPN1 in Station One hall was passing medications. Observation revealed that LPN1 was wearing an N95 mask which was not securely worn in place. One strap of the N95 was hanging and not attached to the back of her head. During the observation, the DON informed LPN1 to secure the N95. LPN1 touched the N95 with her hands in order to secure the mask, however did not perform hand hygiene after touching the mask. LPN1 continued to remove a medication from a blister pack and place the medication in the medication cup without performing hand hygiene. Review of the Indiana State Department of Health policy and procedures, updated 6/29/20 indicated that Adherence to strict hand hygiene should continue for all, particularly before and after resident care. The DON stated that the facility follows all guidelines proposed by Centers for Disease Control and Prevention (CDC) and the Indiana State Department of Health. According to CDC Coronavirus 2019 related to infection control indicated Extreme care must be taken to avoid touching the respirator or facemask .if this must occur Health Care Providers should perform hand hygiene immediately before and after contact to prevent contaminating themselves or others. 6. Observation on 7/6/20 at approximately 6:15pm, with the DON revealed that plastic sheeting was used to create an isolation area for a wall to wall barrier from Station Two to the dedicated Covid-19 Unit. Observation revealed that telescoping plastic poles were being used to support the weight of the plastic which was secured to the the left side of the wall and ceiling area. Duct tape had been used to secure the plastic sheeting to the side walls in order to provide a seal to the areas. However, observation revealed there was an approximate three-inch gap opening between the ceiling and the top of the plastic pole which had not been sealed with duct tape. In addition, two small circular holes were noted in the lower section of the left plastic panel sheet. This observation was conducted by the DON and the Director of Maintenance who noted that an air tight sealed area had not been provided. Review of the Scientific American Journal May 12, 2020 indicated that [MEDICAL CONDITION] could be transmissible through particiles suspended in the air (aerosol transmission). The article further reported that the World Health Organization recently reversed its guidance to say that such transmission, particularly indoors where there are inadequate spaces where infected persons spend long periods of time with others, cannot be ruled out. The research showed that the term (aerosol transmission) refers to transmission of a pathogen via aerosols - tiny respiratory droplets that can be remain suspended in the air, known as droplet nuclei as opposed to larger droplets that fall to the ground within a few feet. 7. Observation of the Covid-19 Unit on 7/7/20 at approximately 6pm, with the DON revealed that staff were leaving for the day shift. Five disposable gowns were noted on individual hooks on the wall next to the exit door of the Covid-19 Unit. Observation revealed that NA1 removed her disposable gown at the exit door and placed it on a hook on the wall next to the exit door. The surveyor asked NA1 about the procedure following the use of the gown and NA1 stated I put it on the hook in case the midnight shift would need to use it. When RN1 who was also working in the Covid-19 Unit was asked about the procedure following the use of the gown, RN1 stated she was unsure of the procedure. The DON who was present during the interviews stated that the facility procedure was to dispose of the individual gowns at the end of the shift. The DON stated I have no idea why the five gowns are hanging on the hooks next to the exit door. Review of CDC guidelines for doffing indicated gown front and sleeves are contaminated, unfasten ties, pull away from neck and shoulders, turn gown inside out and fold or roll into a bundle and discarded. According to CDC-coronavirus 2019 related to infection control recommendations related to Gowns indicated Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use.

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.