STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155801	A. BUILDING _____ B. WING _____	**10/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH	**305 E NORTH ST BOONVILLE, IN 47601**

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. Doors to the rooms of residents on transmission-based precautions were open, staff did not use proper hand hygiene or glove use during care for 1 of 2 residents observed for care, and residents were not wearing or offered a facial covering during care for 1 of 2 observations of care. This had the potential to affect 50 out of 50 residents in the facility. (Resident 45, Resident 2, Resident 16, Resident 3, Resident 4, Resident 46) Findings include: 1. During an observation on 10/22/20 at 9:53 a.m., Resident 16 was identified to be on contact/droplet transmission-based precautions. Resident 16's door was half open. Staff was observed walking by and never closing the door or educating on the need for it to be closed. The room was signed as contact/droplet precautions with a sign that indicated, . KEEP DOOR CLOSED. 2. During an observation on 10/22/20 at 9:55 a.m., Resident 2 was identified to be on contact/droplet transmission-based precautions. Resident 2's door was open, propped open by a trash bin. Staff was observed walking by and never closing the door or educating on the need for it to be closed. The room was signed as contact/droplet precautions with a sign that indicated, . KEEP DOOR CLOSED. 3. During an observation on 10/22/20 at 9:56 a.m., Resident 3 and Resident 4 were identified to be on contact/droplet transmission-based precautions. Resident 3 and Resident 4's door was open, propped open by a trash bin. Staff was observed walking by and never closing the door or educating on the need for it to be closed. The room was signed as contact/droplet precautions with a sign that indicated, . KEEP DOOR CLOSED. 4. During an observation on 10/22/20 at 11:32 a.m., CNA 1 provided pericare for Resident 45. CNA 1 knocked and entered Resident 45's room. CNA 1 grabbed a basin and left the room to fill the basin with water. CNA 1 returned to the room, placed the basin on the bedside table, and left the room to obtain clean linens. CNA 1 returned to the room, and pulled the privacy curtains. CNA 1 donned gloves. No hand hygiene was observed. CNA 1 lowered the bed with her gloved hand, and pulled down Resident 45's blankets. CNA 1 unfastened Resident 45's brief, wet a cloth, added soap, and proceeded to wash Resident 45's periarea. She placed the soiled cloth onto the bedside table. She obtained a clean, wet cloth, and rinsed Resident 45's periarea. CNA 1 placed the soiled cloth onto the bedside table. She rolled Resident 45 to her side, obtained a clean, wet cloth, added soap, and washed Resident 45's buttocks. CNA 1 placed the cloth on the bedside table. She rinsed Resident 45's buttocks with a clean, wet cloth, and then placed it on the bedside table. CNA 1 dried Resident 45 with a clean towel. CNA 1 pulled the soiled brief out from under Resident 45, and placed it into a trash bag. CNA 1 removed her gloves and performed hand hygiene. CNA 1 donned new gloves, and applied barrier cream to Resident 45's buttocks. CNA bagged soiled linen, and removed her gloves. CNA 1 obtained a new brief. CNA 1 donned new gloves without performing hand hygiene. CNA 1 put the new brief under Resident 45 and fastened it. CNA 1 removed her gloves. No hand hygiene was observed. CNA 1 pulled up Resident 45's blankets, lowered the bed, and handed Resident 45 the call light. CNA 1 gathered the soiled linens, trash, and hygiene items and left the room. No hand hygiene was observed. Resident 45 did not have a mask on during care, and was not offered a mask or facial covering during care. 5. During an observation on 10/22/20 at 12:40 p.m., CNA 1 and CNA 2 were observed to transfer Resident 46 from her recliner to her bed. Both entered Resident 46's room. CNA 1 donned gloves. No hand hygiene was observed. CNA 2 did not don gloves or perform hand hygiene. CNA 2 applied a gait belt to Resident 46 while sitting in the recliner. Both assisted Resident 46 to stand and pivot to the bed. They assisted Resident 46 to sit on the bed. CNA 2 guided Resident 45's back to lie down with her bare hand, and CNA 1 swung her legs onto the bed. CNA 2 removed the gait belt, still not wearing gloves. Both assisted the resident to scoot up in the bed. CNA 2 removed Resident 46's socks at her request. Both covered the resident and CNA 2 gave Resident 46 her call light. CNA 1 placed pillows on the sides of the resident's arms at her request. CNA 2 raised the head of the bed. CNA 1 removed her gloves and left the room without performing hand hygiene. CNA 2 moved the bedside table over the bed and left the room. No hand hygiene was observed. Resident 46 did not have a mask on during care, and was not offered a mask or facial covering during care. 6. During a review of the facility census form report, provided by the General Manager/Administrator in Training on 10/22/20 at 9:10 a.m., it indicated the facility had 50 residents residing in the facility. During an interview on 10/22/20 at 12:58 p.m., CNA 2 indicated staff should don gloves prior to performing any care with a resident and should perform hand hygiene prior to donning gloves. CNA 2 indicated they only offer a mask to a resident if they are in the hall, not if they are in their rooms or during care. During an interview on 10/22/20 at 1:05 p.m., LPN 1 indicated all contact/droplet transmission-based precaution room doors should be closed at all times, unsure why they were open or propped open. During an interview with the General Manager/Administrator in Training on 10/22/20 at 1:15 p.m., she indicated she knew the doors open was an issue, but the residents liked them open, and it was a constant battle. During an interview with a visiting Administrator on 10/22/20 at 1:25 p.m., she indicated staff just needs to be reeducated on mask use with care. The facility is aware of the mask use during care. During a review of the current policy, Isolation- Initiating Transmission-Based Precautions, revised 5/20/20, provided by the General Manager/Administrator in Training on 10/22/20 at 1:40 p.m., indicated, .Post the appropriate notice on the room entrance door so that all personnel will be aware of the precautions, or be aware that they must first see a nurse to obtain additional information about the situation before entering the room. This facility's process for notification is a sign posted on the resident's door which reads, SEE POSTING. On 10/22/20 at 1:40 p.m., The General Manager/Administrator in Training provided a copy of one of the signs posted on the contact/droplet precaution room doors. It indicated, .Special Droplet/Contact Precautions .KEEP DOOR CLOSED . During a review of the current policy, Covid-19 PPE- Mask/Face Shield Usage, dated 9/5/20, provided by the General Manager/Administrator in Training on 10/22/20 at 1:40 p.m., indicated, .Cognitively impaired residents will also wear cloth masks when out of their room or while being provided personal care/services as much as is feasible with their condition . During a review of the current policy, Handwashing/Hand Hygiene, revised 4/1/20, provided by the General Manager/Administrator in Training on 10/22/20 at 1:40 p.m., indicated, .In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub before and after direct contact with residents, .before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, after contact with objects in the immediate vicinity of the resident, after removing gloves. Hand hygiene is always the final step after removing and disposing of personal protective equipment. The use of gloves does not replace handwashing/hand hygiene . 3.1-18(b) 3.1-18(l)

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