STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155248	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-BRENTWOOD	30 E CHANDLER AVE EVANSVILLE, IN 47713

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. Doors to isolation rooms were observed open for 1 of 1 resident on droplet precautions, precaution signage was missing from 3 of 5 isolation rooms, staff was not donning PPE (personal protection equipment) appropriately, clean linens were left uncovered on top of PPE (personal protection equipment) carts on 1 of 5 halls, and COVID-19 test swabs were stored overnight in a resident refrigerator on the ACU unit(memory care unit). (Resident D, Resident F, Resident G, 500 unit, ACU unit) Findings include: 1. During an observation during the initial tour on 7/8/20 at 9:37 a.m., Resident D's door was open and had a stop sign indicating to speak with a nurse prior to entering. No signage was noted to indicate the type of precaution or PPE was to be used prior to entering the room. A PPE cart was observed in the hallway outside the room. During an observation on 7/9/20 at 8:18 a.m., Resident D's door was open and had a stop sign indicating to speak with a nurse prior to entering. A PPE cart was observed in the hallway outside the room. During a review of Resident D's clinical record on 7/8/20 at 1:20 p.m., [DIAGNOSES REDACTED]. A care plan, dated 7/1/20, I require droplet isolation related to: COVID-19 precautions due to recent precautions. Follow isolation precaution guidelines as ordered. Inform me and my visitors of necessary precautions. Provide me an isolation cart and signage on my room door. 2. During an observation during the initial tour on 7/8/20 at 9:37 a.m., Resident F had a stop sign on the door indicating to speak with a nurse prior to entering it. No signage was noted to indicate the type of precautions or PPE was to be used prior to entering the room. A PPE cart was observed in the hallway outside the room. During an observation on 7/9/20 at 8:20 a.m., Resident F's door was closed and had a stop sign on the door indicating to speak with a nurse prior to entering it. No signage was noted to indicate the type of precautions or PPE was to be used prior to entering the room. A PPE cart was observed in the hallway outside the room. During a review of the clinical record on 7/9/20 at 11:23 a.m., Resident F's [DIAGNOSES REDACTED]. A nurses' note, dated 7/4/20 8:07 a.m., indicated, During assessment this morning, resident noted and confirmed by this nurse and another nurse to have nits throughout hair as well as bite marks on his scalp. DON contacted, facility procedure initiated. Care plans, dated 7/6/20, indicated altered skin integrity non pressure related to: nits and bite marks to scalp, as follows: I require contact isolation related to head lice. Interventions included, but were not limited to, follow isolation precaution guidelines as ordered, inform me and my visitors of necessary precautions, monitor for signs and symptoms due to possible bites from head lice, monitor my vital signs as needed and report changes as needed, notify physician as needed, provide all services to me in a private room with no roommate to include, all meals, all medication, all therapy, all activities and all treatments, provide me an isolation cart and signage on my room door. 3. During an observation during the initial tour on 7/8/20 at 9:37 a.m., Resident G's door lacked signage on the door related to isolation precautions. A PPE cart was observed in the hallway outside the room. During an observation on 7/9/10 at 8:21 a.m., Resident G's door lacked signage on the door related to isolation precautions. A PPE cart was observed in the hallway outside the room. During a review of the clinical record for Resident G on 7/9/20 at 9:07 a.m., Resident G's [DIAGNOSES REDACTED]. A care plan dated 6/29/20 was as follows: contact isolation to right lower extremity [MEDICAL CONDITION] infection. Interventions included, but were not limited to, administer antibiotics and treatments as ordered by physician, follow precautions set by facility, provide isolation cart in room and signage on door. A nurses' note, dated 6/29/20 11:47 a.m., Resident is to be on contact isolation for 14 days while on antibiotic therapy [MEDICAL CONDITION] of rt (sic) lower leg wound. Wound bed is covered with water proof dressing. Resident notified and educated on contact isolation. 4. During an observation on 7/8/20 at 9:24 a.m., CNA 4 was observed to don PPE outside Resident G's room. CNA 4 donned a gown, left it untied, donned a hair bonnet, and entered Resident G's room. CNA 4 did not perform hand hygiene or don gloves prior to entering Resident G's room. Resident G was on contact isolation. 5. During an observation on 7/8/20 at 9:28 a.m., a stack of clean linens was noted on the PPE cart on the 500 hall. During an interview on 10:48 a.m. with CNA 5, indicated clean linens should always be on a linen cart and covered, not left sitting in the hallway uncovered. During an interview with the DON (Director of Nursing) and ADON (Assistant Director of Nursing) on 7/8/20 at 10:16 a.m., the signs should have been placed on the doors and the types of precautions should have been noted. PPE should have been donned, gown, bonnet, gloves, and hand hygiene should have been performed prior to entering a contact precaution isolation room. During an interview on 7/9/20 at 10:05 a.m. with RN 3, she indicated signage was placed, but staff was sabotaging the survey process by moving the signs and hiding them. RN 3 indicated signage should have been in place and doors closed on isolation rooms. 6. On 7/8/20 at 9:15 a.m., during the initial tour of the locked Alzheimer's Care Unit (ACU), a full size refrigerator was observed in the dining room. The refrigerator was locked, and a sign was taped to door which indicated Do Not Use. On 7/8/20 at 11:00 a.m., two pictures were received from a confidential source. The first picture was undated, and revealed a box of COVID-19 test swabs on the middle shelf of the refrigerator on the ACU unit. It was the only refrigerator on the ACU unit. The test swabs were in biohazard bags and placed in a cardboard box. A pitcher of tea, a large container of applesauce, and Ensure (supplement) were placed on the top shelf. The bottom shelf appeared to have other unidentifiable items. The second picture, dated 7/3/20, had a half gallon of milk and the large container of applesauce and Ensure on the top shelf, including other unidentifiable items behind the containers. The bottom shelf had unidentifiable items. The middle shelf held the cardboard box of test swabs in the biohazard bags. RN 2 indicated at that time that she thought the refrigerator had been locked since the previous Friday, 7/3/20. RN 2 indicated the facility was awaiting a new refrigerator. The Alzheimer's Unit Director also indicated at that time that she thought the refrigerator had been locked since the previous Friday, when residents had been tested for the COVID-19 virus. During a confidential interview, it was revealed that they had seen a box containing COVID-19 test swabs in the ACU refrigerator on 7/3/20 at 6:00 a.m., and also at 1:30 p.m. They informed different staff members, who didn't seem concerned. The refrigerator also contained food and drinks for the residents, and was not locked. A sign was not on the door that informed staff not to use the refrigerator. During a confidential interview, it was revealed that a box containing COVID -19 test swabs was seen in the ACU refrigerator on 7/3/20. Food and drinks were also in the refrigerator. There was no lock on the door, and no sign on the door. They informed another staff member. During a confidential interview, it was revealed that a box containing COVID-19 test swabs was seen in the ACU refrigerator on 7/3/20. The refrigerator was opened to obtain a drink for a resident, and they saw the box. They mentioned it to LPN 2, who was testing residents that day. LPN 2 informed them it was not her responsibility. During a confidential interview, the ACU refrigerator was opened and a box of COVID-19 test swabs was observed. There was no lock on the door, and no signs on the door. They were unsure of the date, but thought it was 7/4/20. On 7/8/20 at 12:25 p.m., during an interview with LPN 2, she indicated she had heard rumors that a box of COVID-19 test swabs were in the ACU refrigerator. She indicated she had not seen it, but reported the rumors to the Director of Nursing (DON). On 7/9/20 at 9:10 a.m., during an interview with RN 2, she indicated she was working on 7/3/20 on the ACU. She indicated she was unaware of any concerns regarding the ACU refrigerator. She indicated she received a text from the DON on

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) 7/3/20 at approximately 5:30 p.m., asking her if anything had happened on 7/3/20. RN 2 indicated that was the first time that she heard about a box of COVID-19 test samples being stored in the refrigerator. On 7/9/20 at 10:05 a.m., during an interview with RN 3, she indicated staff testing for COVID-19 was performed on 7/1/20 and 7/2/20. She indicated she did not put the COVID-19 swabs in the ACU refrigerator, but had heard the samples were put in there. She said she received a phone call from the DON on either 7/1/20 or 7/2/20 regarding the tests being in the refrigerator. RN 3 indicated the test swabs should not be in that ACU refrigerator, and to take them out, clean the refrigerator, and put a lock on it. RN 3 indicated the previous tests had been in the Physical Therapy (PT) room refrigerator, but the PT room was locked and they didn't have a key. On 7/9/20 at 10:25 a.m., during an interview with the DON, she indicated the facility was testing staff on 7/2/20. She indicated it was very late, approximately 11:30 p.m., and she had nowhere else to put the COVID-19 test samples. The PT room was locked and she didn't have a key. She was unable to contact the Maintenance Director. So she informed the 2 night shift staff working on ACU that night to guard the refrigerator. The DON indicated that LPN 2 was to remove the test swabs the next morning. During a review of the current policy, Infection Prevention and Control Program Policy, revised 5/12/20, provided by the DON on 7/8/20 at 9:40 a.m., it indicated, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. It is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. . Prevention of infection .educating staff and ensuring that they adhere to proper techniques and procedures .implementing appropriate isolation precautions when necessary; and following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). During a review of the current policy, Infection Control Policy, revised 8/16/18, provided by the DON on 7/8/20 at 9:40 a.m., it indicated, The facility must establish and maintain an Infection and Prevention and Control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .standard and transmission based precautions to be followed to prevent spread of infections; when and how isolation should be used for a resident; including but not limited to; the type and duration of the isolation, depending upon the infectious agent or organism involved, and a requirement that the isolation should be the least restrictive possible for the resident under the circumstances. The hand hygiene procedures to be followed by staff involved in direct resident contact. During a review of the current policy, Isolation-Categories of Transmission Based Precautions, revised 6/24/28, provided by Medical Records on 7/9/20 at 10:59 a.m., indicated, Transmission-based precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others .Based on CDC definitions, three types of Transmission-Based Precautions (airborne, droplet, and contact) have been established .droplet .keep the door closed and the resident in the room .all individuals must wear approved respiratory when entering the room .Signs, The facility will implement a system to alert staff to the type of precaution the resident requires, this facility utilizes the following system for identification of airborne precautions .Contact precautions .in addition to standard precautions, implement contact precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment .Gloves and handwashing. In addition to wearing gloves as outlined under standard precautions, wear gloves when entering the room. Wear a disposable gown upon entering the Contact Precautions room or cubicle .Droplet Precautions .In addition to standard precautions, implement droplet precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets .The facility will implement a system to alert staff and visitors to the type of precaution the resident requires. During a review of the current policy, Departmental (Environmental Services)- Laundry and Linen Level III, revised 4/4/19, provided by Medical Records on 7/9/20 at 11:30 a.m., it indicated, Clean linen will remain hygienically clean .through measures designed to protect it from environmental contamination, such as covering clean linen carts. The facility lacked a written policy related to storage of Covid-19 test samples. This Federal tag relates to Complaint IN 088. 3.1-18(b)