STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINE HAVEN HEALTH AND REHABILITATION CENTER	**3400 STOCKER DR EVANSVILLE, IN 47720**

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 -** Few	**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 for 2 of 3 residents observed during care. Residents were not provided facial coverings during personal care, a staff member was observed not wearing a facial covering or social distancing, and a water cup was observed outside of a room which was under droplet precautions. (Resident 46, Maintenance 1, Resident 63, CNA 2, Resident 21) Findings include: On 9/15/20 at 8:35 a.m., the DON (Director of Nursing) indicated the facility had 9 residents on the COVID-19 unit and 1 resident who was on droplet precautions on the 100 unit as the resident's roommate had tested positive for COVID-19. He indicated Resident 63 was on droplet precautions. 1. On 9/15/20 at 10:03 a.m., CNA 1 was observed to be providing Resident 46 a shower. CNA 1 handed the resident a clean washcloth to cover her face. After washing the resident's hair, CNA 1 disposed of the washcloth in the soiled linen container. The resident was not provided any facial covering throughout the shower. On 9/15/20 at 10:37 a.m., CNA 1 indicated the facility did not provide facial coverings for the residents when personal care was being provided. 2. On 9/15/20 at 10:45 a.m., Maintenance 1 was observed talking to Maintenance 2 in a room with no mask on and not social distancing. Maintenance 1's mask was observed in his shirt pocket. On 9/15/20 at 10:55 a.m., LPN 1 indicated Maintenance 1 should be wearing a mask and social distancing. She would remind him immediately to apply his mask and social distance. 3. On 9/15/20 at 10:50 a.m., Resident 63 was observed to have her call light on. A droplet precaution sign and PPEs (personal protective equipment) were outside of her room. CNA 2 was observed to don PPEs and enter the resident's room. No hand hygiene was observed. The resident had indicated she has spilled her drinking water on her bed. CNA 2 doffed her PPEs and exited the room to obtain a clean sheet and bedspread. CNA 2 donned PPEs, entered the room, changed the resident's sheet and bedspread, and removed the resident's water cup, placing it outside the room on the hall rail. CNA 2 doffed her PPEs, obtained the water cup from the rail and carried it to the nurse's station where she placed ice and water into it. CNA 2 returned down the hall, dropped a roll of plastic bags onto the floor and picked them up, placing them onto the hall rail. She donned a gown and gloves, obtained the water cup from the hall rail, and took the cup back into the resident's room. No hand hygiene was ever observed. On 9/15/20 at 10:57 a.m., CNA 2 indicated hand hygiene should be completed before and after resident care, if your hands become soiled, and if you picked anything up off of the floor. 4. On 9/15/20 at 10:57 a.m., CNA 2 was observed to provide care to Resident 21. CNA 2 obtained clean towels, performed hand hygiene, and donned gloves. She obtained a clean, wet washcloth and wiped Resident 21's left eye. CNA 2 also provided pericare (washing of the genitals and anal area) to the resident. The resident did not wear any facial covering during the personal care. On 9/15/20 at 11:10 a.m., CNA 2 indicated residents do not wear masks during personal care only when they are out of their rooms. It would be a good idea though for the residents to wear them during care. On 9/15/20 at 3:02 p.m., the DON indicated the staff had been educated regarding the resident's having facial covering during personal care. Maintenance 1 had been reminded several times to wear a mask and social distance. The water cup should not have been removed from the resident's room and instead the resident should have been given a new cup with ice water in it. The water cup should have been disposed of in the resident's trash. The current facility policy, revision date July, 2014, provided by the DON on 9/15/20 at 3:15 p.m., included, but was not limited to, Single use items are disposed of after a single use. The current facility policy, revision date September, 2010, provided by the DON on 9/15/20 at 3:15 p.m., included, but was not limited to, the objectives of wearing a mask were to prevent transmission of infectious agents through the air and to protect the wearer from inhaling droplets. The facility lacked a policy regarding the wearing of masks by residents during care. 3.1-18(b) 3.1-18(l)

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.