STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING _____ B. WING _____	**10/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOOVERWOOD	**7001 HOOVER RD INDIANAPOLIS, IN 46260**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to transport linen in a sanitary manner on the 1A unit, failed to ensure staff used appropriate Personal Protective Equipment (PPE) when entering a room on isolation precautions and failed to ensure staff preformed hand hygiene after exiting a room which was under isolation precautions on the 2A unit for 2 of 5 units reviewed for infection control practices. (1A and 2A) Findings include: 1. During a random observation, on the 1A unit, on 10/09/20 at 10:13 a.m., CNA 1 was observed walking down the east hall carrying unbagged soiled laundry against her clothing. At this time, she indicated soiled linen and clothing should be bagged in the room and then transported out of the room and soiled linens and laundry should not have been carried up against her clothing 2. During a walk through observation, on 10/09/20 at 10:30 a.m., with the Infection Preventionist (IP) in attendance on the 2A unit, LPN 2 was observed in Resident 1's room, with an isolation cart and sign on the door, without an isolation gown or gloves on. LPN 2 then exited the room carrying a breakfast tray, she did not perform hand hygiene in the room or after exiting the room. At this time, the IP indicated staff was to wear the appropriate PPE into the resident's room, as it was an isolation room. During an interview, on 10/09/20 at 10:32 a.m., LPN 2 indicated she should have used the appropriate PPE before entering the room. She heard the resident yelling for help, as the resident wanted a blanket, and just entered the room. The record for Resident 1 was reviewed on 10/09/20 at 11:40 a.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. 3. During an observation, on 10/09/20 at 10:30 a.m., with the IP in attendance on the 2A unit, Employee 3 was observed in Resident 2's room without an isolation gown or gloves on. Resident 2 was on isolation and the isolation cart was right outside the door of the room. The employee was touching items on the bedside table and resting her hands on the table. Employee 3 then exited the room. She did not perform hand hygiene while in the room or upon exiting the room. At this time, Employee 3 indicated she should have preformed hand hygiene after exiting the room and she did not see the isolation cart when she entered, but should have used a gown and gloves prior to entering the room. The record for Resident 2 was reviewed on 10/09/20 at 11:50 a.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. During an interview, on 10/09/20 at 12:06 p.m., the IP indicated strict isolation means the resident could not come out of their room or go to therapy, they needed to stay in their room for the full term of the order. Anytime a resident was in isolation it would be posted and the staff knew to wear the appropriate PPE for the isolation. The two residents (1 and 2) were on droplet precautions. A current facility policy, titled Isolation, dated as last revised 06/20 and provided by the Assistant Director of Nursing (ADON) on 10/09/20 at 10:39 a.m., indicated .Staff shall wear appropriate Personal Protective Equipment upon entering an isolation room .Hand hygiene shall be done upon entering and upon leaving the isolation room A current facility policy, titled Linen Removal, dated as last revised 06/20 and provided by the Assistant Director of Nursing (ADON) on 10/09/20 at 10:39 a.m., indicated .Staff will properly handle dirty linen in an effort to prevent further contamination of residents and staff .All dirty linen shall be bagged in appropriate container before being removed from the room .Staff should carry linen away from body and uniform to prevent contamination 3.1-18(a) 3.1-18(l) 3.1-19(g)(1)

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