STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155758	A. BUILDING _____ B. WING _____	**09/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASBURY TOWERS HEALTH CARE CENTER	**102 W POPLAR ST GREENCASTLE, IN 46135**

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, record review, and interview, the facility failed to follow Centers for Disease Control (CDC) guidance during a pandemic and ensure infection control practices for COVID-19 were followed for personal protective equipment (PPE) use during resident care to prevent potential exposure to staff and residents for 24 of 41 residents not diagnosed with [REDACTED]. During an interview on 9/19/20 at 1:00 p.m., the Director of Nursing (DON) indicated there were currently 17 residents positive for COVID-19 residing in the building and they had 5 positive staff currently. The facility map of isolation rooms had not changed since the previous survey on 9/18/20. As a precaution all staff in the building were wearing N95 masks even in the green zone (areas without COVID -19 residents or residents being observed for COVID-19). If staff were providing direct care to residents they were wearing a gown. She was unaware of the guidance for staff to wear goggles or face shields in the building for direct care of all residents during a COVID-19 outbreak. The DON confirmed there was one gown per room hanging on the outside of the residents' room doors. Staff were utilizing one gown per resident room and staff were sharing the gown. The gowns were changed daily or every shift. The DON was not aware of the risk of exposure from the shared gowns or of the guidance to utilize one gown per staff per resident to prevent exposure. During observations, on 9/19/20 from 3:49 p.m. to 4:10 p.m., the residents' room doors on the Health Care unit and First Floor unit were observed with one gown per room hanging on the outside of the doors. There were 22 resident rooms observed for 24 residents in the green and yellow areas. There were 9 residents' rooms in the red area. During an interview on 9/19/20 at 4:07 p.m., Licensed Practical Nurse (LPN) 2 indicated one hallway on the Health Care unit was the red (COVID-19 positive) unit and the other hallway was the yellow (COVID-19 status unknown) unit. Both units had one gown for the staff to wear inside the rooms hanging on the doorways to the rooms. The only difference in PPE between the red and yellow units was the red unit staff also wore shoe covers in addition to gowns, masks, and face shields. On 9/19/20 at 1:38 p.m., the DON provided the policy, dated 3/12/2020, titled, Infection Outbreak Response and Investigation, and indicated it was the current policy. The policy indicated, Policy: The facility promptly responds to outbreaks of infectious diseases within the facility to stop transmission of pathogens and prevent additional for infections .Standard precautions will be emphasized. Transmission-based precautions will be implemented as indicated for the particular organism .Staff will be educated on the mode of transmission of the organism, symptoms of infection, and isolation or other special procedures. This includes special environmental infection control measures that are warranted that are warranted based on the organism and current CDC guidelines The Indiana Department of Health Long -Term Care guidance titled, Use of Face shields or protective eyewear/goggles, dated 9/2/20, indicated, To align with updated Centers for Disease Control and Prevention guidelines, Indiana Department of Health is now recommending the use of eye protection as a standard safety measure to protect long term care healthcare personnel (HCP) who provide essential direct care within 6 feet of the resident, especially when doing procedures that lead to sprays and splashes. This includes the delivery of care for non-COVID residents in facilities with 1 or more symptomatic and/or COVID positive residents, and those who are quarantined in COVID positive, symptomatic, or quarantined residents who are already in transmission-based precautions - Droplet - Contact CDC guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 7/15/20, indicated, .Below are changes to the guidance as of July 15, 2020 .Added language that protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays CDC guidance titled, Strategies for Optimizing the Supply of Isolation Gowns, dated 3/17/20, indicated, .Extended use of isolation gowns Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort) 3.1-18(b)(2)

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.