STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER-BRANDYWINE	745 N SWOPE ST GREENFIELD, IN 46140

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 ensure a new admission resident, a re-admission resident, and a [MEDICAL TREATMENT] resident were placed into droplet isolation precautions (measures used to prevent the spread of diseases) upon admission or return to the facility and the facility failed to ensure containers for contaminated personal protective equipment (PPE) were in isolation rooms for 3 of 3 residents reviewed for isolation precautions (Resident 1, 2, and 3). Findings include: 1. On 6/19/20 at 11:20 a.m., during a tour of the facility with Registered Nurse (RN) 3, Resident 1 was observed from the North hallway, in her private room, sitting in a recliner and watching television. Resident 1's door had a sign posted, which indicated to See Nurse Before Entering Room. No biohazard trash container was observed in Resident 1's room. By Resident 1's door, against the wall in the North hallway, was observed a plastic three-drawer storage container with supplies of personal protective equipment (PPE) and two plastic, lidded trash containers, one of the containers was marked on the lid, linen, and the second trash container was lined with a red, biohazardous trash bag liner. On 6/19/20 at 11:22 a.m., RN 3 indicated, Resident 1 was isolated to her room for 14 days, because she was a new admission to the facility and the facility followed the Centers for Disease Control (CDC) guidance for new admissions into long term care facilities and placed the Resident 1 into isolation precautions for 14 days. On 6/19/20 at 11:43 a.m., Certified Nursing Assistant (CNA) 5, indicated, she cared for all the residents on the North hallway, including Resident 1, and she wore a face mask, while she worked in the facility. Prior to entering a resident's isolation room, she donned (put on) isolation personal protective equipment (PPE) in the hall of gown and gloves. When she finished with the resident's care, she removed her isolation gown and gloves and placed them into the biohazardous, red-bag, lined trash container, located in the North hallway. On 6/19/20 at 11:50 a.m., RN3 indicated the used biohazardous PPE trash containers and the soiled-linen containers should have been in each one of the isolation residents' rooms, not in the North hallway. On 6/19/20 at 12:47 p.m., Resident 1's isolation room now was observed by the door to have a trash container lined with a red, biohazardous trash bag liner. CNA 5, wearing a face mask, donned a gown and gloves, but no goggles nor a face shield, entered Resident 1's room with a lunch tray. CNA 5 placed the lunch tray on the bedside table and assisted Resident 1 to sit up in her recliner, by placing a pillow support behind Resident 1 in the recliner. CNA 5 assisted Resident 1 with her meal tray, by cutting up the food and assisted with a fork Resident 1 to eat bites of food from the lunch plate. CNA 5 handed the fork to Resident 1, sanitized her hands, removed her gown and gloves and placed the used gown and gloves into the biohazard, red-bag trash container, located by Resident 1's door. On 6/19/20 at 12:55 p.m., Resident 1 was observed to push her bedside table away from herself and stood up from the recliner, to adjust the pillow that had been propped behind her. CNA 5, wearing a mask, donned a gown and gloves (no goggles nor face shield), went into Resident 1's isolation room, and assisted Resident 1 to sit in a wheelchair. CNA 5 sanitized her hands, removed her gown and gloves and placed the used gown and gloves into the biohazard, red-bag trash container, located by Resident 1's door. Resident 1's medical record was reviewed on 6/22/20 at 12:20 p.m. Resident 1 was admitted to the facility from the hospital, on 6/18/20. Diagnoses, included but not limited to, dementia with behavioral disturbance (an overall term for diseases and conditions characterized by a decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities) and [MEDICAL CONDITION] (mental illness) with delusions. A physician's orders [REDACTED]. A care plan, dated 6/19/20, indicated Resident 1 would remain in droplet isolation related to prevention of COVID-19 (respiratory infection) with interventions included, but not limited to, follow facility protocol for COVID-19 screening/precautions, don (put on) and doff (remove) PPE while caring for Resident 1, and educate the staff providing care, along with the resident and visitors of COVID-19 signs, symptoms, and precautions. A care plan, dated 6/22/20, indicated Resident 1 was at risk for psychosocial well-being concern related to medically imposed restrictions related to COVID-19 precautions. A goal for the resident was to not show a decline in psychosocial well-being or experience adverse effects. Interventions on the care plan, included but were not limited to, observe Resident 1 for psychosocial and mental status changes and provide support and allow the resident to express feelings, fears and concerns. 2. On 6/19/20 at 11:23 a.m., during a tour of the facility with Registered Nurse (RN) 3, Resident 2 was observed from the North hallway, in his private room, lying on his bed, and watching television. Resident 2's open door had a sign posted, which indicated to See Nurse Before Entering Room. No biohazard trash container was observed in Resident 2's room. A plastic three-drawer storage container with supplies of personal protective equipment (PPE) and two plastic, lidded trash containers, one of the containers was marked on the lid, linen, and the second trash container was lined with a red, biohazardous trash bag liner, were observed in the North hallway. On 6/19/20 at 11:25 a.m., RN 3 indicated, Resident 2 was isolated to his room for 14 days, because he was a re-admission to the facility from the hospital, and the facility followed the Centers for Disease Control (CDC) guidance for new admissions into long term care facilities and placed the Resident 2 into isolation precautions for 14 days. On 6/19/20 at 11:43 a.m., Certified Nursing Assistant (CNA) 5, indicated, she cared for all the residents on the North hallway, including Resident 2, and she wore a face mask, while she worked in the facility. Prior to entering a resident's isolation room, she donned (put on) isolation personal protective equipment (PPE) in the hall of gown and gloves. When she finished with the resident's care, she removed her isolation gown and gloves and placed them into the biohazardous, red-bag, lined trash container, located in the North hallway. On 6/19/20 at 11:50 a.m., RN3 indicated, the used biohazardous PPE trash containers and the soiled-linen containers should have been in each one of the residents' isolation rooms, not in the North hallway. On 6/19/20 at 1:03 p.m., Resident 2's isolation room was now observed by the door to have a trash container lined with a red, biohazardous trash bag liner. CNA 5, wearing a face mask, donned a gown and gloves, but no goggles nor a face shield, entered Resident 2's room, emptied urine from a container into the bathroom toilet, washed her hands at the bathroom sink, removed her gown and gloves, placed the used gown and gloves into the biohazardous trash container, and retrieved Resident 2's lunch tray. Resident 2's medical record was reviewed on 6/22/20 at 11:03 a.m. Resident 2 was readmitted to the facility from the hospital, on 6/11/20. Diagnoses, included but not limited to, unspecified sequelae of cerebral infarction (a stroke with damage of tissues in the brain) and old [MEDICAL CONDITION] infarction ([MEDICAL CONDITION].) A physician's orders [REDACTED]. A care plan, dated 6/19/20, indicated Resident 2 required isolation related to COVID-19 with a goal of Resident 2 to remain free from signs and symptoms of infection. Interventions, included but not limited to, provide me an isolation cart and signage on my door, don and doff PPE while caring for Resident 2, and follow isolation precaution guidelines as ordered. 3. On 6/19/20 at 11:28 a.m., during a tour of the facility with Registered Nurse (RN) 3, Resident 3 was observed from the North hallway, in his private room, lying on the bed and watching television. Resident 3's door had a sign posted, which indicated to See Nurse Before Entering Room. No biohazard trash container was observed in Resident 3's room. A plastic three-drawer storage container with supplies of personal protective equipment (PPE) and two plastic, lidded trash containers, one of the containers was marked on the lid, linen, and the second trash container was lined with a red, biohazardous trash bag liner, were observed in the North hallway. On 6/19/20 at 11:32 a.m., RN 3 indicated, Resident 3 was isolated to his room, because he was a [MEDICAL

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) TREATMENT] resident who left the facility three days a week for [MEDICAL TREATMENT]. The facility followed the Centers for Disease Control (CDC) guidance for [MEDICAL TREATMENT] residents in a long term care facilities and placed the Resident 3 into isolation precautions, due to leaving the facility to a [MEDICAL TREATMENT] center three days a week. On 6/19/20 at 11:43 a.m., Certified Nursing Assistant (CNA) 5, indicated, she cared for all the residents on the North hallway, including Resident 3, and she wore a face mask, while she worked in the facility. Prior to entering a resident's isolation room, she donned (put on) isolation personal protective equipment (PPE) in the hall of gown and gloves. When she finished with the resident's care, she removed her isolation gown and gloves and placed them into the biohazardous, red-bag, lined trash container, located in the North hallway. On 6/19/20 at 1:10 p.m., CNA 5, wearing a face mask, was observed to don (put on) a gown and gloves, without googles nor a face shield, knocked and entered Resident 3's room. When CNA 5 re-opened Resident 3's room door, she had removed her gown and gloves while she was in the room, came out of the room, carrying Resident 3's used lunch tray and placed the tray onto the used tray cart located in the hallway. Resident 3's medical record was reviewed on 6/22/20 at 10:56 a.m. Diagnoses, included but not limited to, end stage [MEDICAL CONDITION] (kidney failure) and dependence of renal (kidney) [MEDICAL TREATMENT]. A physician's orders [REDACTED]. A care plan, dated 3/13/20, indicated Resident 3 was at risk for signs and symptoms of COVID-19 with a goal to not exhibit any signs or symptoms of COVID-19. Interventions on the care plan included, but were not limited to, droplet isolations precautions related to [MEDICAL TREATMENT] 3 times a week, follow facility protocol for COVID-19 screening/precautions, and document and report if Resident 3 had any signs or symptoms of fever, coughing, sneezing, sore throat, respiratory issues and report promptly to Resident 3's doctor. A care plan, dated 3/13/20, indicated Resident 3 was at risk for psychosocial well-being concern related to medically imposed restrictions related to COVID-19 precautions. A goal for the resident was to not show a decline in psychosocial well-being or experience adverse effects. Interventions on the care plan, included but were not limited to, observe Resident 3 for psychosocial and mental status changes and provide support and allow the resident to express feelings, fears and concerns. On 6/22/20 at 12:41 p.m., the ED indicated, all new admission, re-admission, and [MEDICAL TREATMENT] residents should be in droplet isolation precautions for 14 days upon return to the facility. Droplet isolation precautions, included, staff to wear appropriate PPE while providing care for the isolated residents of face mask, gown, gloves, and goggles or a face shield. At that time she provided and identified as a current facility policy, a document, titled 2001 MED-PASS, Inc., dated August 2016. The policy indicated, .Transmission-Based Precautions . Droplet Precautions Potential exposure to microorganisms through droplets, via cough, sneeze, etc. .Use Standard Precautions with transmission based isolation .Wash hands after every resident contact .Wear gloves when contact with resident environment .Wear mask or face shield if you come within 3 feet of the resident The Centers for Disease Control and Prevention (CDC), dated 4/28/20, indicated, for all Long Term Care Facilities to, .Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their exposure (or admission). Testing at the end of this period could be considered to increase certainty that the resident is not infected .All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown 3.1-18(b)(1)