

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 155217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
NAME OF PROVIDER OF SUPPLIER WATERS OF HUNTINGBURG, THE		STREET ADDRESS, CITY, STATE, ZIP 1712 LELAND DR HUNTINGBURG, IN 47542	
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	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to implement infection control measures to prevent the spread of COVID-19. Staff did not wash hands with soap, or for the recommended duration for 2 of 2 resident care observations, gloves were not changed during assistance with a shower for 1 of 2 resident care observations, clean linen touched staff scrubs before being put up, staff took dirty linen from a resident room into another resident room, and therapy room equipment was not disinfected after each resident use. (Resident 3, Resident 7, Resident 15, Resident 17) Findings include: 1. On 10/22/20 at 8:50 A.M., PTA 17 was observed to assist Resident 3 into the therapy room with a walker. Resident 3 did not have a mask on. PTA 17 was wearing a surgical face mask, and a face shield. Resident 3 was the only resident in the therapy room during her session. PTA 17 asked Resident 3 to put on a pair of surgical gloves during her session. Afterward, Resident 3 was escorted back to her room. The therapy room was observed to not be disinfected when Resident 3 left. At that time, PTA 17 indicated staff did not disinfect the therapy room between residents, because they are asked to put on gloves. She indicated the therapy room would only be cleaned if the resident did not wear gloves, or depending on the type of therapy received. 2. On 10/22/20 at 9:30 A.M., CNA 21 was observed to assist Resident 7 with a shower. After coming into the shower room, CNA 21 put a glove on her right hand, and touched the hand rail with that hand, then put on the left glove. CNA 21 then pulled the shower chair over to Resident 7, took off Resident 7's pants and brief, and with the same gloved hands raised the dirty linen bin with her hand and put the dirty clothes in it. CNA 21 pushed the shower chair into the shower area, and began the shower. With the same gloved hands, CNA 21 washed Resident 7's hair, wet a rag for the resident to use on her face, and continued to wash the rest of the resident. During the shower, CNA 21 touched her face shield 3 times. The resident was brought out of the shower area, and CNA 21 assisted to dry her. CNA 21 lifted the dirty linen bin with her hand, and put in the towels used to dry off. CNA 21 then assisted Resident 7 to get dressed with clean clothes. CNA 21 assisted to put her shirt on, then pulled a clean brief and pants over her legs, put socks on, then shoes, while wearing the same gloves. CNA 21 then took the gloves off, and picked up the remaining towel that was on the floor with her bare hands, opened the dirty linen bin with her hand, and placed the towel in the bin. CNA 21 then put on a pair of clean gloves, and assisted Resident 7 to get the rest of the way dressed, and sit in her wheelchair. CNA 21 took her gloves off, then handed Resident 7 her mask that she was wearing prior to her shower with her bare hands, touching both sides of the mask. CNA 21 wheeled Resident 7 to her room, and assisted to brush her hair. CNA 21 then went into the bathroom, and washed her hands with no soap for 15 seconds under running water. CNA 21 then took the dirty linen off of Resident 7's bed without wearing gloves, placed the linen into pillowcases, and touched her face mask twice while taking her glasses off and putting them back on. She then adjusted her face shield again, and took the pillowcases with the dirty linen out of the room. CNA 21 did not wash or sanitize her hands. CNA 21 then walked across the hall to Resident 17's room. CNA 21 was observed with the pillowcases in one hand, and touching the resident's back and shoulder with the other non-gloved hand. During an interview on 10/22/20 at 10:07 A.M., CNA 21 indicated handwashing should be performed when going into a resident's room, during care, and when taking gloves off. She indicated handwashing should be performed for at least 20 seconds. 3. On 10/22/20 at 10:12 A.M., LPN 32 was observed to perform a dressing change for Resident 15's left foot. When the dressing was complete, LPN 32 was observed to wash her hands for 10 seconds. 4. On 10/22/20 at 12:04 P.M., Housekeeper 28 was observed on Unit 1 taking clean clothes to resident rooms. She was observed to touch her face mask 5 times, and face shield 1 time. Without sanitizing her hands, she continued to take the resident's clean clothes into their rooms. 5. On 10/22/20 at 12:12 P.M., Housekeeper 9 was observed on Unit 1 transferring clean linen from a cart to the linen closet. Each time linen was taken off of the cart, it was rubbed against Housekeeper 9's scrubs before placed in the linen closet. During an interview on 10/22/20 at 12:57 P.M., the DON (Director of Nursing) indicated staff should wash their hands with soap and water, before entering a resident room, before and after care, and to use hand sanitizer in between times, unless hands are visibly soiled. She indicated if staff were to touch their face mask or face shield while wearing them, their hands should be sanitized or washed with soap and water, and that handwashing should take 1 minute total with a 20 minute lather with soap. She indicated inservices and education was completed with all staff across all shifts at least weekly, with monitoring of all infection control practices. On 10/22/20 at 1:50 P.M., a current non-dated PPE and Universal Precautions Guideline document was provided, that indicated standard precautions should be used when handling/transport of linen. On 10/22/20 at 1:50 P.M., a current non-dated Disinfection of Frequently Used Medical Items document was provided, that indicated when a multi-use piece of equipment is being used between resident's, the item should be cleaned with an approved EPA agent. On 10/22/20 at 1:50 P.M., a current non-dated Hand Hygiene Guidelines document was provided, and indicated Apply generous amount of soap to hands and run hands together vigorously for at least 20 seconds. The duration of the entire procedure should be approximately 40-60 seconds, per evidence based practice. 3.1-18(b) 3.1-18(l)</p>		

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.