	T OF HEALTH AND HU R MEDICARE & MEDI						RM APPROVED IB NO. 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155264		ILDING	DNSTRUCTION 00	(X3) DATE COMPI 11/10	LETED
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE TRAIGHT LINE PIKE		
GOLDEN	N LIVING CENTER	-GOLDEN RULE			IOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
F 0000		,					
Bldg. 00	Control Survey. Survey dates: Nov Facility number: 0 Provider number: AIM number: 100 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Typ Medicare: 17 Medicaid: 52 Other: 14 Total: 83	155264 288220 e:	F 00	00	Preparation, submission ar implementation of this Plan Correction does not constit an admission or agreement with the facts and conclusi- set forth on the survey repo Our Plan of Correction was prepared and executed as a means to continuously imp the quality of care and com with all applicable federal a state requirements. The facility respectfully requests a desk review of co responses to this survey.	of cute ons ort. rove ply nd	
F 0880 SS=E Bldg. 00	accordance with 4 Quality review con 2021 483.80(a)(1)(2)(4 Infection Prevent §483.80 Infection The facility must infection prevent designed to prov comfortable envit the development communicable di	npleted on November 16, (e)(f) ion & Control					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 155264 B. WING 11/10/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2330 STRAIGHT LINE PIKE GOLDEN LIVING CENTER-GOLDEN RULE RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility: (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections: (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: G6K111 Facility ID: 000165 If continuation sheet Page 2 of 9

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CENTERS FOR STATEMEN	<b>F OF HEALTH AND HU R MEDICARE &amp; MEDIC</b> VT OF DEFICIENCIES OF CORRECTION		r í	JILDING	DNSTRUCTION 00	FO	LETED
	NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-GOLDEN RULE			2330 S <sup>-</sup>	ADDRESS, CITY, STATE, ZIP CODE TRAIGHT LINE PIKE OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	disease; and (vi)The hand hygi followed by staff i contact. §483.80(a)(4) A s	t contact will transmit the ene procedures to be nvolved in direct resident ystem for recording d under the facility's IPCP					

§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. F-880 Infection Control & 1.) Based on interview and record review, the F 0880 11/28/2021 facility failed to properly prevent/and or contain Prevention What corrective actions will be COVID-19 by not excluding an unvaccinated staff member that was showing signs and accomplished for those symptoms of SARS-CoV-2 (Covid-19) from residents found to have been affected by the deficient work for 1 of 5 staff members reviewed for SARS-CoV-2 management and precautions. practice? Residents Based on the content in the 2.) Based on observation, interview, and record review, the facility failed to properly prevent/and citation the facility is unable to or contain COVID-19 by not providing identify Residents : H, I, J, K, L, transmission-based precautions signage for 11 of M, N, O, P, Q, R, S, T and U 24 residents in transmission-based precautions Staff Based on the content in the due to high exposure to SARS-CoV-2 and failed to properly dispose of used personal protective citation the facility is unable to equipment during 1 of 2 infection control identify staff member: C.N.A. 4, rounds. (Residents K, L, M, N, O, P, Q, R, S, T, LPN3, C.N.A. 3 and U) Immediately implement specific plan for

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and the corrective actions taken by the

Personnel must handle, store, process, and transport linens so as to prevent the spread

facility.

of infection.

§483.80(e) Linens.

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155264 B. WING 11/10/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2330 STRAIGHT LINE PIKE GOLDEN LIVING CENTER-GOLDEN RULE RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Findings include: resident/residents/area/others identified in the deficiency to 1. An interview with Administrator (Admin) on correct. 11/9/2021 at 11:30 a.m., indicated Maintenance Director had come to her office on 11/1/2021 Specific Staff prior to clocking in and said that he had been The Executive Director was feeling ill over the weekend. Point of care educated on the screening antigen for SARS-CoV-2 tests were completed guidelines to include ensuring in her office and resulted as negative. unvaccinated staff members that Maintenance Director was allowed to work are showing signs and symptoms 11/1/2021 and 11/2/2021. Routine Polymerase of Covid-19 are excluded from Chain Reaction (PCR) testing was scheduled for work or entering the facility. 11/1/2021 due to the high county positivity rate and was completed the afternoon of 11/1/2021How other residents having the for Maintenance Director. On 11/2/2021 potential to be affected by the evening she received notification that same deficient practice will be Maintenance Director had tested positive for identified and what corrective SARS-CoV-2 per the PCR test collected on action will be taken 11/1/2021. Maintenance Director was excluded All residents that reside at the from work starting 11/3/2021 and returned to facility have the potential to be work on 11/8/2021. affected by the alleged deficient practice The respiratory line list for November 2021, The facility conducted an audit of reviewed on 11/9/2021 at 3:30 p.m., indicated all residents to ensure the that Maintenance Director was exhibiting signs resident/residents of cough, fever, and body aches with symptom affected/potential affected has onset of 10/29/2021. been isolated in Transmission Based Precautions according to The screening logs for Maintenance Director, CDC and IP recommendations reviewed on 11/10/2021 at 12:08 p.m., indicated with appropriate signage and PPE he screened in on 11/1/2021 at 6:54 a.m., on set up and receptacle for disposal 11/2/2021 at 7:22 a.m., and on 11/8/2021 at of used PPE. 6:54 a.m. The facility conducted a 7 day A CMS (Centers for Medicare and Medicaid look back audit to ensure all staff Services) memorandum QSO-20-38-NH are screened and screening REVISED on 04/27/2021 indicated, " ... Staff who documented and assessed at the do not test positive for COVID-19 but have beginning of their shift for fever symptoms should follow facility policies to and respiratory symptoms, determine when they can return to work." including, but not limited to,

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## DEPARTMENT OF HEALTH AND **CENTERS FOR MEDICARE & ME**

	T OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED IB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· · ·			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			LETED
		155264	B. WI	NG		11/10	/2021
	PROVIDER OR SUPPLIE		•	2330 S	ADDRESS, CITY, STATE, ZIP CODE TRAIGHT LINE PIKE		
GOLDEN	N LIVING CENTER	-GOLDEN RULE		RICHM	IOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Control and Preven Covid-19" revised symptoms of SAR not limited to, feve of breath, fatigue, : nausea and vomitin An Indiana State F Care Covid-19 Cli 9/28/21, indicated,	lealth Department Long-term nical Guidance, revised on "Staff with symptoms of			shortness of breath, new or changed cough and sore thro Ensure screening for other symptoms of COVID-19, including, but not limited to change in taste or smell and gastrointestinal symptoms. T staff were not permitted to wo presenting with symptoms of illness. Follow CDC and facili policy.	<sup>r</sup> hat ork if ty	
	restricted from wo if it is a COVID-19 been ruled out acc	be tested immediately and be rk until isolation is completed 0 case, or until COVID-19 has ording to Considerations for ntigen Tests in Long-Term			What measures will be put i place and what systemic changes will be made to en- that the deficient practice de not recur	sure	

A policy entitled, "Returned to Work Criteria for Healthcare Personnel with Confirmed or Suspected COVID-19 Infection", was provided by DON on 11/9/2021 at 3:30 p.m. The policy indicated, " ... The criteria for HCP returning to work using a symptom-based strategy consists of: a. HCP [Health Care Personnel] with mild to moderate illness who are not moderately to severely immunocompromised: i. At least 10 days have passed since symptoms first appeared and ii. At least 24 hours have passed since last fever without the use of fever-reducing medications and iii. Symptoms (e.g., cough shortness of breath) have improved ..."

Care Facilities (CDC 1.15.21)". The referenced

document, Considerations for Interpretation of Antigen Tests in Long-Term Care Facilities

(CDC 1.15.21), is a flow chart that indicated if

antigen is negative, a confirmatory NAAT (Nucleic Acid Amplification Test) is indicated.

an Health Care Personnel is symptomatic and an

demonstration, including, but not limited to, mask, respirator devices, gloves, gown and eye protection and proper disposal of used PPE. Staff educated on the guidelines for proper signage for Zones (Green, Yellow, Red and AGP) How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations. If issues/trends are identified, then audits will continue based on QAPI recommendation. If none

Staff educated on the guidelines

PPE specific to zones with return

for Donning/Doffing PPE and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			· /	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155264	A. BU B. WI	ILDING NG	00		apleted 10/2021	
NAME OF 1			-	STREET	ADDRESS, CITY, STATE, ZIP	CODE		
NAME OF	PROVIDER OR SUPPLIE	ĸ		2330 S	TRAIGHT LINE PIKE			
GOLDEN	N LIVING CENTER	-GOLDEN RULE		RICHM	10ND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CC	ADDECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG			DATE	
					noted, then will comp			
		th the Director Of Nursing			based on a prn basis.			
		021 at 11:25 a.m., during			By what date the sys			
		our, indicated that Residents Q, R, S, T, and U should be in			changes be completed	ea:		
					11-20-2021			
	yellow transmission-based precautions due to exposure to a health care personnel starting							
	11/9/2021.							
	An observation ma							
		re was no signage or						
		unit or doors for Residents K,						
		R, S, T, or U to be in yellow						
		l precautions due to high-risk						
		ive health care personnel. The grage found on the unit was						
		-						
	right of the storage room, indicated this unit was in a green zone. The sign indicated staff needed to wear a universal surgical mask, face shield or goggles, and gloves. The DON removed this							
	signage from the v							
		DON, on 11/10/2021 at 11:28						
		did not know why the signage						
	1	ted, but she would have staff						
	-	nsmission-based precaution esidents immediately.						
	signage for these r	esidents inimediatery.						
		CNA 4, on 11/10/2021 at						
		ed she was aware the residents						
	-	nsmission-based precautions						
		why the signage had not						
		access to personal protective						
		ng gowns, N-95, face shields, on-unit storage room.						
	An observation ma	ide on 11/10/2021 at 12:12						
	p.m., showed CNA	4 was in the process of						
		nsmission-based precaution						
	signs on residents'	doors and support staff were						

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NTERS FOR MEDICARE & MEDICAID SERVICES						,	OMB NO. 0938-03		
	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 155264		A. E	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/10/2021		
NAME OF	PROVIDER OR SUPPLIEF		•	STREET A	DDE				
GOLDEN LIVING CENTER-GOLDEN RULE					TRAIGHT LINE PIKE OND, IN 47374				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR		(X5)		
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE PROPRIATE	COMPLETIC		
TAG	<ul> <li>placing isolation ca equipment througho</li> <li>Per signage provide 11/10/2021 at 12:08</li> <li>transmission-based contact/droplet prece utilize an N95, face down for resident c</li> <li>An N95 filtering face abbreviated N95 resparticulate-filtering meets the U.S. Nati Occupational Safety classification of air filters at least 95%</li> <li>A policy entitled, "I Transmission-Based by Admin on 11/10</li> <li>policy indicated, " implement a system precautions residen a copy of the green, signage from the St</li> </ul>	d by Administrator on 8 p.m., yellow precautions are autions that staff would shield/goggles, gloves, and are. cepiece respirator, commonly spirator, is a facepiece respirator that onal Institute for 7 and Health N95 filtration, meaning that it of airborne particles. filtration- Categories of d Precautions", was provided /2021 at 12:08 p.m. The Signs - The facility will a to alert staff to the type of t requires" Admin provided yellow, and red stop light ate Health Department as ge for transmission-based		TAG	DEFICIENCY		DATE		
	2:01 p.m., indicated personal protective needing to re-use su During an infection on 11/10/2021 at 11 that two used blue of hanging outside of	h the DON on 11/9/2021 at that the facility had plenty of equipment and were not upplies at this time. control rounding completed :40 a.m., it was observed lisposable gowns were Resident H's room from the t I's room two disposable							

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OF DEFICIENCIES CORRECTION VIDER OR SUPPLIER	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155264	A. B	UILDING /ING	NSTRUCTION 00 DDRESS, CITY, STATE, ZIP CODE	(X3) DATE COMPL 11/10/	LETED
VIDER OR SUPPLIER	-		STREET A	DDPESS CITY STATE 710 CODE		
	NAME OF PROVIDER OR SUPPLIER		2330 ST			
GOLDEN LIVING CENTER-GOLDEN RULE			RICHMO			
			ID			(X5)
REGULATORY OR	LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	}E 'RIATE	COMPLETIC DATE
ight of the door fro 'here were no isola ersonal protective r J in yellow transu- an interview with I Jurse) on 11/10/20 he was unsure what vas not aware of th he was going to low an interview with C 1:51 a.m., indicate cesident 's room was nd they were going an observation at 1 he isolation barrels laced liners, and bo are isolation room er assignment. An interview with A t 12:08 p.m., indic uidance of the Stat Centers for Disease ontrol, including tr oning and utilization quipment. A procedure entitled ersonal Protective administrator on 11	<ul> <li>m the same hook without.</li> <li>tion barrels to collect used equipment for Residents H, I, mission-based precautions.</li> <li>LPN 3 (Licensed Practical 21 at 11:47 a.m., indicated at happened to the barrels and e gowns in the hallway, but ok for them.</li> <li>CNA 2 on 11/10/2021 at d the blue gowns outside of as therapy or housekeeping g to reuse them.</li> <li>1:57 a.m., LPN 3 had found in the soiled utility room, egan distributing them to the as (Resident H, I, and J) on</li> <li>Administrator, on 11/10/2021 at definition of personal protective</li> <li>d, "Sequence for Removing Equipment", was provided by L/10/2021 at 12:08 p.m. The</li> </ul>					
	(EACH DEFICIEN <u>REGULATORY OR</u> lue gowns were ob ight of the door fro 'here were no isola ersonal protective r J in yellow transf an interview with I Jurse) on 11/10/20 he was unsure what vas not aware of th he was going to loo an interview with C 1:51 a.m., indicate tesident 's room was nd they were going an observation at 1 he isolation barrels laced liners, and b mee isolation barrels laced liners, and b mee isolation room er assignment. an interview with A t 12:08 p.m., indicate centers for Disease ontrol, including tr oning and utilization quipment. A procedure entitled coument indicated	an interview with Administrator, on 11/10/2021 t 12:08 p.m., indicated the facility follows the uidance of the State Health Department and Centers for Disease Control for infection ontrol, including transmission-based precaution oning and utilization of personal protective	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) lue gowns were observed to be hanging to the ight of the door from the same hook without. 'here were no isolation barrels to collect used ersonal protective equipment for Residents H, I, r J in yellow transmission-based precautions. An interview with LPN 3 (Licensed Practical Murse) on 11/10/2021 at 11:47 a.m., indicated the was unsure what happened to the barrels and vas not aware of the gowns in the hallway, but the was going to look for them. An interview with CNA 2 on 11/10/2021 at 1:51 a.m., indicated the blue gowns outside of tesident 's room was therapy or housekeeping nd they were going to reuse them. An observation at 11:57 a.m., LPN 3 had found the isolation barrels in the soiled utility room, laced liners, and began distributing them to the there isolation rooms (Resident H, I, and J) on er assignment. An interview with Administrator, on 11/10/2021 t 12:08 p.m., indicated the facility follows the uidance of the State Health Department and centers for Disease Control for infection ontrol, including transmission-based precaution oning and utilization of personal protective quipment. A procedure entitled, "Sequence for Removing tersonal Protective Equipment", was provided by administrator on 11/10/2021 at 12:08 p.m. The ocument indicated, "GownFold or roll into	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAGItue gowns were observed to be hanging to the ight of the door from the same hook without. here were no isolation barrels to collect used ersonal protective equipment for Residents H, I, r J in yellow transmission-based precautions.TAGAn interview with LPN 3 (Licensed Practical Hurse) on 11/10/2021 at 11:47 a.m., indicated he was unsure what happened to the barrels and vas not aware of the gowns in the hallway, but he was going to look for them.TAGAn interview with CNA 2 on 11/10/2021 at 11:51 a.m., indicated the blue gowns outside of tesident 's room was therapy or housekeeping and they were going to reuse them.TAGAn observation at 11:57 a.m., LPN 3 had found ne isolation barrels in the soiled utility room, laced liners, and began distributing them to the tree isolation rooms (Resident H, I, and J) on er assignment.TAGAn interview with Administrator, on 11/10/2021 tt 12:08 p.m., indicated the facility follows the uidance of the State Health Department and Centers for Disease Control for infection ontrol, including transmission-based precaution oning and utilization of personal protective quipment.Precedure entitled, "Sequence for Removing tersonal Protective Equipment", was provided by xdministrator on 11/10/2021 at 12:08 p.m. The ocument indicated, "GownFold or roll into	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       PREFIX TAG         Use gowns were observed to be hanging to the ight of the door from the same hook without. here were no isolation barrels to collect used ersonal protective equipment for Residents H, I, r J in yellow transmission-based precautions.       TAG         an interview with LPN 3 (Licensed Practical iurse) on 11/10/2021 at 11:47 a.m., indicated he was unsure what happened to the barrels and zas not aware of the gowns in the hallway, but he was going to look for them.       TAG         an interview with CNA 2 on 11/10/2021 at 11:51 a.m., indicated the blue gowns outside of tesident's room was therapy or housekeeping nd they were going to reuse them.       TAG         an observation at 11:57 a.m., LPN 3 had found he isolation barrels in the soiled utility room, laced liners, and began distributing them to the tree isolation rooms (Resident H, I, and J) on er assignment.       TAG         an interview with Administrator, on 11/10/2021 to 21:08 p.m., indicated the facility follows the uidance of the State Health Department and 'enters for Disease Control for infection ontrol, including transmission-based precaution oning and utilization of personal protective quipment.       TAG         approximation of personal protective quipment.       Sequence for Removing tersonal Protective Equipment", was provided by doministrator on 11/10/2021 at 12:08 p.m. The ocument indicated, "GownFold or roll into	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       TAG         Ubg gowns were observed to be hanging to the ight of the door from the same hook without. here were no isolation barrels to collect used ersonal protective equipment for Residents H, I, r J in yellow transmission-based precautions.       Image: Comparison of the same show without. here were no isolation barrels to collect used ersonal protective equipment for Residents H, I, r J in yellow transmission-based precautions.       Image: Comparison of the same show without. here was usave what happened to the barrels and ras not aware of the gowns in the hallway, but he was usaver what happened to the barrels and ras not aware of the gowns outside of tesident's room was therapy or housekceping nd they were going to reuse them.       Image: Comparison of the same same same same same same same sam

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DEPARTMENT	EPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-0391	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	LETED	
		155264	B. WING			11/10/2021		
	NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-GOLDEN RULE			2330 S	ADDRESS, CITY, STATE, ZIP CODE IRAIGHT LINE PIKE OND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR TAG DEFICIENCY)		BE	(X5) COMPLETION DATE		
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