STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366361	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OTTERBEIN MONCLOVA	5069 OTTERBEIN WAY MONCLOVA, OH 43542

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 -** Immediate jeopardy **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of the facility's infection control policies, the facility failed to place ten of ten residents in House 5085 on transmission-based precautions, to include full Personal Protective Equipment (PPE), after two staff working in the House tested positive for COVID-19. As a result of these failures, the facility had a potential risk for a COVID-19 outbreak that could affect all ten residents living in House 5085. The facility Administrator and the Assistant Clinical Vice President (ACVP) were advised on 09/17/20 at 6:05 PM of concerns rising to immediate jeopardy at F880 infection control for failure to implement transmission-based precautions and use of full PPE with residents exposed to COVID-19. The facility provided a removal plan that was accepted on 09/18/20 at 5:14 PM. The facility immediately implemented isolation carts outside the 10 resident rooms and established full PPE precautions in House 5085. The DON established full transmission-based precautions (eye protection, N95 masks, and gloves) and signs on all doors. The DON re-educated with competency training the nursing staff currently working on proper donning and doffing of PPE, transmission-based precautions, and signs and symptoms of COVID-19. The removal plan was validated by observations of staff wearing PPE, isolation carts with PPE outside of residents' rooms, and interviews with staff. Completion of staff education was verified by review of the in-service sign in sheets dated 09/17/20 and 09/18/20. The deficient practice remained at a D pattern and the severity lowered to potential for more than minimal harm following the removal of the immediate jeopardy at midnight on 09/18/20. Findings include: Review of the CDC guidance titled, Response to Newly Identified [DIAGNOSES REDACTED]-CoV-2 infected HCP (healthcare practitioner) or Residents dated 4/30/20, revealed direction: HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset: .Determine which residents received direct care from and which HCP had unprotected exposure to HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset. Residents who were cared for by these HCP should be restricted to their room and be cared for using all recommended COVID-19 PPE until results of HCP COVID-19 testing are known. If the HCP is diagnosed with [REDACTED]. Review of the CDC Guidance titled, Considerations for Use of [DIAGNOSES REDACTED]-CoV-2 [MEDICATION NAME] Testing in Nursing Homes, updated 8/27/20, revealed that A COVID-19 outbreak response in a nursing home is triggered when a resident or HCP tests positive for [DIAGNOSES REDACTED] CoV-2. The guidance further indicates that, Factors that increase the probability of infection include recent exposure to someone diagnosed with [REDACTED]. and an outbreak response should be initiated immediately when a resident or healthcare practitioner tests positive. During the entrance conference on 09/17/20 at 8:30 AM, the Administrator stated two State tested Nursing Assistants (STNA4 and STNA5) had tested positive for COVID-19 in September. Both STNA4 and STNA5 worked in House 5085, one of five houses making up the facility. During the entrance conference, the Administrator and Director of Nursing (DON) stated STNA4 called into the facility on [DATE] complaining of a sore throat and body aches. A nasopharyngeal specimen for COVID-19 was collected from STNA4 on 09/11/20 at the facility's drive-thru testing site for employees. The result of the testing came back to the facility on [DATE] as positive for COVID-19. Employee record review revealed STNA4 last worked in House 5085 on 09/09/20, during the second shift (2:30 PM to 10:30 PM). Further interview of the Administrator and DON during the entrance conference, revealed STNA5 was tested for COVID-19 during a random testing of staff on 09/15/20. STNA5's test results came back positive for COVID-19 on 09/16/20. Employee record review revealed STNA5 last worked in House 5085 on 09/15/20, on third shift (10:30 PM to 6:30 AM). Observation of House 5085 on 09/17/20 at 11:10 AM revealed there was no signage on the resident's doors to indicate that any type of transmission-based precautions were implemented for the ten residents exposed to COVID-19. Further observation revealed no PPE visible for staff to use during the care of the residents. The only PPE the staff was wearing were masks. Observation on 09/17/20 at 11:10 AM in House 5085, revealed Resident (R) 4 was self-propelling in her wheelchair, wearing a mask on her chin, with her nose and mouth exposed, trying to get out the front door of the house. Medical record review revealed the facility admitted R4 to the facility on [DATE] with a [DIAGNOSES REDACTED]. Further observation on 09/17/20 at 11:10 AM, revealed STNA14, wearing only a face mask, redirected R4, explaining to the resident she could not go outside because it was raining. The Chaplin and the Therapist, both wearing PPE consisting only of a mask, entered the front door as the resident continued to try to leave the house. The Chaplin held the resident's hand trying to calm her. The Therapist also spoke to the resident from a distance of approximately three feet. During an interview on 09/17/20 at 1:10 PM, the Director of Nursing (DON) stated, The residents in House 5085 were put in Room Restriction Isolation when we got STNA4's positive result back on 09/13/20. When asked to clarify what she meant by Room Restriction Isolation, the DON responded, Meals in their rooms. Wear masks when in common areas of the house, if not possible to keep residents in their rooms. During an interview on 09/17/20 at 1:15 PM, the Administrator stated, Our policy states (to implement transmission-based precautions and use of full PPE) when COVID-19 is suspected not (when) exposed. The Administrator indicated she thought Room Restriction Isolation was adequate. Review of the facility's policy titled, COVID-19 Policy and Procedure, revision date 09/12/20, revealed, Upon identification of a resident with known or suspected COVID-19, immediate infection prevention and control measures will be placed . Place resident in private room in designated area with contact and droplet precautions including signage on resident room .Full PPE should be worn per CDC guidance for the care of any resident with known or suspected COVID-19 (under CDC conservation guidance) . If COVID-19 transmission occurs in the facility, partners (staff) should wear full PPE for the care of all resident irrespective of COVID-19 symptoms on the affected unit. During an interview with the ACVP, who also is the active Infection Preventionist (IP) at this facility, on 09/17/20 at 1:30 PM, the ACVP/IP verified that the residents in House 5085 were exposed to COVID-19 when STNA4 and STNA5 were diagnosed with [REDACTED]. The ACVP/IP verified staff should have been using PPE, to include gloves, gowns, eye protection, and masks. The ACVP/IC stated, We have a communication problem related to the understanding of exposure vs. suspected. The ACVP/IP verified that suspected and exposed residents should be considered Persons Under Investigation (PUI) and should be in transmission- based precautions.

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.