STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365881	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ECHO MANOR EXTENDED CARE CTR	10270 BLACKLICK EASTERN ROAD NW PICKERINGTON, OH 43147

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** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interview and facility policy review the facility failed to maintain adequate infection control practices for residents who were in quarantine for COVID-19 to decrease the risk of spreading COVID-19. In addition, the facility failed to ensure all staff were knowledgeable of the current requirements for personal protective use (PPE) when entering the rooms for residents in quarantine for COVID-19. This affected three residents (#1, #2 and #3) and had the potential to affect all 67 residents residing in the facility. Findings include: Review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) 3.0 assessment had not been completed as of 08/25/20, however initial interview with Resident #1 revealed he was cognitively capable of answering questions appropriately. Review of Resident #1's physician's orders [REDACTED]. However, there was no documentation related to when the quarantine period was to end until a late entry was made on 08/25/20. Late entry notes made on 08/25/20 indicated the resident and physician were notified of the facility policy of a 14 day quarantine for new admissions, and a physician order [REDACTED]. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review revealed Resident #2 was placed in quarantine for COVID-19 due to being a new admission. The quarantine status was initiated upon admission (08/11/20 at 7:00 P.M.) and the quarantine was to end on 08/25/30 at 6:59 P.M. Review of Resident #3's medical record revealed the resident was originally admitted to the facility on [DATE]. She was sent to the hospital due to a medical issue and then readmitted to the facility on [DATE]. The resident's [DIAGNOSES REDACTED]. Review of Resident #3's Minimum Data Set (MDS) 3.0 assessment, dated 07/14/20 revealed the resident was cognitively intact with a Brief Interview for Mental Status score of 15. Review of Resident #3's orders and progress notes, dated 08/14/20 revealed the resident was placed on quarantine precautions starting on 08/14/20 with an end date 14 days later. On 08/24/20 at 1:05 P.M. and on 08/25/20 at 8:05 A.M. interview with Licensed Practical Nurse (LPN) #104 revealed when entering a room for a resident who was in quarantine for COVID-19, staff were only required to wear goggles and a mask. No additional personal protective equipment (PPE) was required to enter these residents rooms. LPN #104 revealed the facility did not have any type of PPE shortage. LPN #104 also verified the residents who were in quarantine were those residents being monitored for signs/symptoms of COVID-19. On 08/24/20 at 1:10 P.M. interview with the Administrator revealed the facility expectation was that the same precautions were to be taken for those residents in quarantine for COVID-19 as those residents who were in isolation in regards to PPE use. On 08/25/20 observations made between 7:30 A.M. to 9:15 A.M. revealed an observation of State tested Nursing Assistant (STNA) #101 taking Resident #2's vital signs (in the resident's room). When the STNA was done taking the resident's vital signs, she went directly to Resident #1's room with the same vital signs machine to take Resident #1's vital signs as well. While performing these tasks, the STNA was wearing a mask, goggles, and gloves. The STNA was not wearing a gown. Observation of both Resident #2 and Resident #1's room revealed signs on both resident's doors to see the nurse prior to entering the resident's room. While STNA #101 was in Resident #1's room, taking his vital signs without a gown on, STNA #102 grabbed a gown from the PPE cabinet, knocked on Resident #1's door and reminded STNA #101 that this resident was in quarantine precautions and the STNA needed to put a gown on. After prompted by STNA #102, STNA #101 applied the gown. During the observation, STNA #101 also walked into Resident #3's room wearing only gloves to assist this resident with setting up her breakfast tray. Resident #3 was observed to have a sign to see the nurse prior to entering on her door, which indicated she was on quarantine precautions. On 08/25/20 interview with LPN #103 (at 8:23 A.M.), STNA #101 (at 8:35 A.M.) and STNA #102 (at 8:42 A.M.) confirmed residents with a sign on their door indicated staff/visitors needed to see the nurse before entering and were in quarantine or isolation for COVID-19. In addition, all three staff members revealed a person under investigation (PUI) meant staff needed to wear a gown, gloves, mask, and goggles when they entered these rooms. The staff interviewed revealed information about residents who were placed on or taken off quarantine/isolation status was discussed during morning meeting/shift change, and then it would be relayed to everyone else on the shift. STNA #101 confirmed she had gone into Resident #1, Resident #2 and Resident #3's rooms without a gown on, and confirmed all three residents had signs on their doors indicating they were on quarantine status. STNA #102 also confirmed he gave STNA #101 a gown while she was in Resident #2's room due to Resident #2 still being on quarantine precautions. On 08/25/20 at 8:46 A.M. interview with Resident #3 revealed she was aware when staff came into her room they were to have full PPE on at all times. The resident revealed most of the time, staff would have a mask, goggles and maybe gloves. Review of the facility undated Admission of COVID Positive or Suspected COVID Positive Residents in a Pandemic Situation policy revealed, readmission of facility residents sent to the emergency room or hospital would be reviewed in the same manner. When possible, these readmissions would be placed in a dedicated assignment in an effort to closely monitor the resident. These residents would be quarantined for 14 days from date of admission. The policy also stated consider having healthcare professionals (HCP) wear all recommended PPE (gown, gloves, eye protection, N95 respirator or, if not available, a facemask) for the care of all residents, regardless of presence of symptoms. Implement protocols for extended use of eye protection and facemasks.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE