STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365047	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FIRST COMMUNITY VILLAGE HEALTHCARE CTR	**1800 RIVERSIDE DRIVE COLUMBUS, OH 43212**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident interview, staff interview, and review of facility policy, the facility failed to promote dignity by not providing privacy during one Resident (#42) of one observed during wound care and incontinence care. The facility also failed to provide privacy for one Resident (#43) of one observed with their name taped to a wheelchair. The facility census was 45. Findings include: 1. Medical record review revealed Resident #42 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #42's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was significantly cognitively impaired. The resident required extensive assistance of two people Activities of Daily Living (ADLs). Observation of incontinence care and pressure ulcer wound care for Resident #42 with Licensed Practical Nurse (LPN) # 223 and assisted by LPN #312 on 03/04/20 at 11:24 A.M., revealed LPN #223 removed the resident's clothing. Resident #42's window had blinds, which were opened. There was a person observed walking around outside near the window. The wound was cleansed and care provided as ordered. LPN #223 then put a new brief and clothes on the resident. Interview with LPN #223 on 03/04/20 at 11:37 A.M. confirmed the window blind was up and the resident was exposed the whole time during incontinence and wound care. LPN #223 revealed the blind is normally always down, however she forgot to shut it. She confirmed there was a person walking around outside near the window of Resident #42's room. Review of the facility policy titled Privacy and Confidentiality, dated August 2013, revealed full visual privacy will be maintained during resident care and treatment to include pulling privacy curtains, closing doors and window coverings. 2. Medical record review revealed Resident #43 was admitted to the facility 09/07/16 with [DIAGNOSES REDACTED]. Review of the MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. Observations on 03/02/20 at 10:16 A.M., on 03/03/20 at 8:37 A.M., and on 03/04/20 at 8:38 A.M. revealed Resident #43 in her wheelchair in the dining room. Her wheelchair had two strips of pink tape and one strip of blue tape with her first initial of her first name, and full last name taped to the back of her chair. Interview on 03/04/20 at 11:35 A.M. with State tested Nursing Assistant (STNA) #211 confirmed Resident #43 had two strips of pink duct tape and one strip of blue painter's tape with her first initial of her first name, and full last name on her wheelchair. The STNA confirmed it was not dignified to have tape on the back of Resident #43's wheelchair with her name on it.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on staff interview, review of facility policy and procedures, the facility failed to implement their Water Management Plan to reduce the risk, growth and spread of the Legionella Disease. This had the potential to affect all 45 residents of the facility. Findings include: Interview on 03/03/20, at 11:12 A.M. with the Maintenance Supervisor (MS) #368 revealed he took resident rooms water temperatures daily, however, did not keep a record of the temperatures. Interview on 03/03/20, at 2:36 P.M. with MS #368 and Executive Director (ED) #376 revealed they did not flush systems that had standing water. The ED revealed they had a contracted company who tested their water systems two times a year for the Legionella infection. Interview on 03/04/20, at 11:30 A.M. with the Executive Director #376 confirmed they do not have documentation of performing the required maintenance measures listed in their Water Management Plan. Review of the Legionella Policy-Environmental Policy and Procedure (February 2018) revealed the mission of the facility is to maintain environmental and clinical policies and procedures to ensure that when a Legionella infection is identified, actions are taken to identify the source of the organism, if possible and to reduce the risk of Legionella infection by managing water systems in accordance with the policy. Review of the Water Management Plan (02/18) revealed the facility should be monitoring and recording distal temperatures, chlorine levels, flush low use points, flush eye wash stations, check storage tank temperatures to maintain a temperature of 140 F and drain expansion tanks monthly.

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.