| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366341 | A. BUILDING _____ B. WING _____ | 09/18/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| WAYNE COUNTY CARE CENTER | 876 S GEYERS CHAPEL ROAD WOOSTER, OH 44691 |

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) |
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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to implement a plan to manage residents exposed to COVID-19 that was based on national standards developed to contain the spread of COVID-19. Specifically, a COVID-19 outbreak was identified in the facility on 08/13/20 when one staff tested positive for COVID-19. After this outbreak, staff failed to wear all recommended Personal Protective Equipment (PPE- i.e., gloves, gown, eye protection and respirator or facemask) when providing care for five (Resident (R) 1, R2, R3, R4, R5) of five residents reviewed for transmission-based precautions. This deficient practice had the potential to affect 23 residents residing on the units where the staff who tested positive for COVID-19 worked, out of a census of 37 residents. Findings include: Review of the Centers for Disease and Control and Prevention (CDC) guidance titled Responding to COVID-19, Considerations for the Public Health Response to COVID-19 in Nursing Homes, updated 04/30/20, revealed the following in the section titled, Response to Newly Identified [DIAGNOSES REDACTED]-CoV-2-infected HCP (Health Care Personnel) or Residents: HCP who worked with symptoms consistent with<br>COVID-19 or in the 48 hours prior to symptom onset: .If the HCP is diagnosed with [REDACTED]. Review of the facility's policy from the Nursing Services Policy and Procedure Manual for Long-Term Care MED-PASS titled, Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures, revised April 2020, directed that If there are COVID-19 cases in the facility: Staff wear all recommended PPE (personal protective equipment) (i.e. gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit. The policy did not direct how to care for residents who were exposed to a HCP who became COVID positive. Review of the facility's undated document titled COVID-19 Tracking revealed State tested Nursing Assistant (STNA) 4 was tested for COVID-19 on 08/10/20 and the facility received a COVID positive result on 08/13/20. Review of the facility's Daily Staffing documents revealed STNA4 worked from 6:00 AM to 6:00 PM on 08/08/20, 08/09/20, and 08/11/20 on the B1 and B2 hall, working with two other STNAs. Review of the Daily Census report dated 08/11/20 revealed the facility census was 37 with 23 residents residing on the B1 and B2 Halls. Review of the Infection Control Preventionist (ICP) document revealed that R1, R2 and R3 were tested for COVID-19 on 08/20/20, R4 was tested on [DATE], and R5 was tested on [DATE]. a. Review of R1's Electronic Medical Record (EMR) revealed that on 08/20/20 at 3:00AM, a Nurse's Note documented that R1 was not feeling well and had a temperature of 100.8 degrees Fahrenheit (F). A nurse's note dated 08/20/20 at 12:05 PM in the Progress Notes tab of the EMR documented that a COVID test was obtained, and the resident was moved to the COVID Unit. Review of Lab Report dated 8/23/20 revealed that, based on the sample taken on 08/20/20, the resident had tested positive for COVID-19. Review of R1's Progress Notes tab revealed no information about use of PPE between 08/13/20, when the first COVID-19 outbreak occurred, and 08/20/20 when the resident developed symptoms and was transferred to the COVID-19 unit. b. Review of R2'S EMR revealed that on 08/20/20 at 4:14 AM, a Nurse's Note documented that R2 was not feeling well and had a temperature of 100.2 degrees F at 12:30 AM. A nurse's notes dated 08/20/20 at 7:50 AM revealed the resident was transferred to the COVID Unit due to presumptive COVID-19 and placed on droplet precautions. Review of a Lab Report dated 8/23/20 revealed that, based on a sample taken on 08/20/20, the resident had tested positive for COVID-19. Review of R2's Progress Notes tab revealed no information about use of PPE between 08/13/20, when the first COVID-19 outbreak occurred, and 08/20/20 when the resident developed symptoms and was transferred to the COVID-19 unit. c. Review of R3's EMR revealed that on 08/20/20 at 3:20 AM, a Nurse's Note in the Progress Notes tab documented that R3 had a temperature of 100.7 Degrees F and Tylenol had been administered at 12:20 AM. A nurse's note dated 08/20/20 at 7:50 AM revealed R3 was transferred to the COVID-19 Unit due to presumptive COVID-19 and placed on droplet precautions. Review of a Lab Report dated 8/23/20 revealed that, based on a sample taken on 08/20/20, R3 had tested positive for COVID-19. Review of R3's Progress Notes tab revealed no information about use of PPE between 08/13/20, when the first COVID-19 outbreak occurred, and 08/20/20 when the resident developed symptoms and was transferred to the COVID-19 unit. d. Review of R4's EMR revealed that on 08/22/20 at 10:20 PM, a Nurse's Note in the Progress Notes tab of the EMR documented that R4 had diarrhea and was placed on droplet precautions. Review of a Lab Report dated 08/25/20 revealed that, based on a sample taken on 08/23/20, R4 was positive for COVID-19. Review of R4's Progress Notes tab revealed no information about use of PPE from 08/13/20, when the first COVID-19 outbreak occurred through when the resident began displaying COVID-19 symptoms. e. Review of R5's EMR revealed that on 08/24/20 at 7:30 PM, a Nurse's Note in the Progress Notes tab documented that R5 had a cough and coarse rhonchi (abnormal lung sounds) and at 9:00 PM was moved into the COVID-19 Unit. Review of Lab Report dated 8/25/20 revealed that, based on a sample taken on 08/24/20, R5 was positive for COVID-19. Review of R5's Progress Notes tab revealed no information about use of PPE between 08/13/20, when the first COVID-19 outbreak occurred, and 08/24/20 when the resident developed symptoms and was transferred to the COVID-19 unit.<br>Interview with STNA1 on 09/18/20 at 10:45 AM revealed that she routinely worked on the B1 and B2 Halls. STNA 1 stated that between the first staff outbreak on 08/13/20 and the first resident outbreak on 08/20/20, staff were following standard precautions, and the only PPE staff were using was wearing surgical masks when providing care for residents on these halls. During an interview on 09/18/20 at 1:40 PM, Registered Nurse (RN) 1 stated that she recalled STNA4 was the first COVID positive staff member and the first case of COVID in the facility. The immediate intervention for the residents on the units where STNA4 worked was to increase monitoring from daily to twice a day. RN 1 stated that staff were using a cloth mask, and no other PPE was used until the resident outbreak was identified and residents were moved to the COVID Unit. In the COVID Unit, RN1 stated full PPE, which included N95 masks, body suits, face shields and gloves, was used. During an interview on 09/18/20 at 2:44 PM, the Infection Control Preventionist (ICP) stated that on 08/13/20, the first positive case of COVID-19 was identified with STNA4. The residents and responsible parties were notified about the occurrence by the Administrator and she recalled staff were wearing cloth face masks. The ICP stated that staff working on the halls where STNA4 worked did not immediately begin wearing full PPE after the 08/13/20 outbreak. The ICP stated that she conferred with the Director of Nursing (DON) and Medical Director and she did not know about the CDC guidance for a COVID outbreak. The ICP stated she does monitor the CDC website and it was the intention of the facility to follow CDC guidelines. Further interview with the ICP revealed that if staff had used full PPE when providing care, it would be documented in the progress notes in the EMR. During an interview on 09/18/20 at 3:03 PM, the Medical Director stated that within a day of the outbreak, the facility had a meeting with the(NAME)County Health Department. He recalled the health department didn't think the facility needed to do anything; however, the facility ultimately tested the whole building. When asked what the facility was required to do in response to an outbreak, he stated There's been so many directives, it's very confusing and we have tried to keep on top of them. During an interview on 0918/20 at 3:15 PM, the Administrator stated that in response to the COVID-19 outbreak, she spoke with(NAME)County Health Department for guidance and the use of full PPE was not recommended. The Administrator stated she believed the facility policies provided guidance for an outbreak and she did not know about the guidance provided for new outbreaks by the CDC. |

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.