

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 365583	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2020
NAME OF PROVIDER OF SUPPLIER VILLA CAMILLUS THE		STREET ADDRESS, CITY, STATE, ZIP 10515 E RIVER RD COLUMBIA STATION, OH 44028	
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 0885 Level of harm - Minimal harm or potential for actual harm Residents Affected - Many	<p>Based on review of correspondences sent to resident representatives, staff interview, and facility policy review, the facility failed to notify resident's representatives of a confirmed positive COVID-19 test of a former employee in a timely manner. This had the potential to affect all 57 residents of the facility. Findings include: Review of the correspondences sent to resident representatives, dated 07/31/20, revealed representatives were notified a former employee had tested positive for COVID-19. Interview on 08/17/20 at 9:20 A.M. with the Administrator verified on 07/21/20 the facility was notified a former employee had tested positive for COVID-19. The Administrator further verified correspondences to resident's representative were not sent out until 07/31/20, 10 days after being notified of the positive COVID-19 test. Review of the facility policy titled, COVID-19 reporting, dated 2020, revealed the facility will utilize communication mechanisms that make the information easily accessible to all residents, their representative and families by means of paper notification (newsletter or fact sheet), listservs, website postings and/or recorded telephone messages. Staff notifications will be provided via email, phone messaging blasts and in-person meetings during work shifts. All reporting will be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) to ensure confidentiality of protected health information. This deficiency substantiates Complaint Number OH 979.</p>		

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.