STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365644	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINCHESTER CARE & REHABILITATION	36 LEHMAN DR CANAL WINCHESTER, OH 43110

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review the facility failed to ensure Resident #34 and Resident #166, who required staff assistance for activities of daily living received showers as scheduled to maintain proper grooming and hygiene. This affected two residents (#34 and #166) of three sampled residents reviewed for showers. Findings include: 1. Review of Resident #34's medical record revealed the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #34's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 06/26/20 revealed the resident experienced disorganized thinking and an altered level of consciousness. Resident #34 required extensive assistance from one staff member for bed mobility and eating and total dependence from one staff member for dressing, toilet use and personal hygiene. The resident was not interviewable. Review of Resident #34's care plans, dated 06/26/20 through 07/10/20 revealed the resident had altered neurological status, a self care deficit and poor decision making skills. Resident #34 required tube feedings for nutrition and hydration support. Review of the facility shower schedule revealed Resident #34 was scheduled to receive a shower on Mondays and Thursdays on day shift. Review of Resident #34's shower sheets from June 2020 revealed no evidence the resident received a shower on 06/01/20, 06/04/20, 06/08/20, 06/11/20, 06/18/20 or 06/22/20 as planned. Interview on 06/30/20 at 11:40 A.M. with Registered Nurse (RN) #29 revealed there were many incidents when some of the residents, including Resident #34 did not receive their scheduled showers due to there not being enough direct care staff to provide this care. Interview on 06/30/20 at 1:00 P.M. with the Administrator revealed when a resident receives a shower, a shower sheet was to be completed and if there was not a shower sheet completed, then the resident did not receive a shower. On 07/06/20 at 9:40 A.M. interview with State tested Nursing Assistant (STNA) #92 revealed there were not enough direct care staff members working the floor to provide proper care for the residents and there were times when showers did not get completed due to short staffing. 2. Review of Resident #166's medical record revealed an original admission date of [DATE] and readmission date of [DATE]. The resident had [DIAGNOSES REDACTED]. Review of Resident #166's care plans, dated 10/08/19 through 08/25/20 revealed the resident had a self-care deficit related to neurocognitive disorder and required assistance with activities of daily living. Review of Resident #166's quarterly MDS 3.0 assessment, dated 05/22/20 revealed the resident expressed inattention and disorganized thinking. Resident #166 required supervision from one staff member for bed mobility and extensive assistance from one staff member for dressing, toilet use and personal hygiene. The resident was not interviewable. Review of the facility shower schedule revealed Resident #166 was scheduled to receive a shower on Mondays and Thursdays on day shift. Review of Resident #166's shower sheets for June 2020, revealed no evidence the resident was provided a shower on 06/15/20, 06/18/20, 06/22/20, 06/25/20 or 06/29/20. Interview on 06/30/20 at 11:40 A.M. with Registered Nurse (RN) #29 revealed there were many incidents when some of the residents, including Resident #166 did not receive their scheduled showers due to there not being enough direct care staff to provide this care. Interview on 06/30/20 at 1:00 P.M. with the Administrator revealed when a resident receives a shower, a shower sheet was to be completed and if there was not a shower sheet completed, then the resident did not receive a shower. On 07/06/20 at 9:40 A.M. interview with State tested Nursing Assistant (STNA) #92 revealed there were not enough direct care staff members working the floor to provide proper care for the residents and there were times when showers did not get completed due to short staffing. This deficiency substantiates Master Complaint Number OH 791 and Complaint Number OH 700.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interview, review of staffing schedules and policy review the facility failed to maintain sufficient levels of nursing staff to ensure medications were administered timely and as ordered and to ensure resident showers were completed. This had the potential to affect all 105 residents residing in the facility. Findings include: 1. Review of the facility staffing schedules revealed the facility provided nursing (licensed nurses and State tested nursing assistant (STNA)) staff on two shifts, the day shift and the night shift. Review of the facility provided staffing schedules for 06/17/20, 06/19/20, 06/20/20 and 06/29/20 revealed the following: On 06/17/20 for the day shift there were to be 11 STNAs, however there were only 7.8. For the night shift there were to be 11 STNAs, however there were only 8. On 06/19/20 for the day shift there were to be 11 STNAs, however there were only six. For the night shift there were to be 11 STNAs, however, there were only 6.4. The plan included five licensed nurses for day shift. However, on 06/19/20 there were only four licensed nurses who were documented as working. On 06/20/20 for the day shift there were to be nine STNAs, however there were only six. For the night shift there were to be 11 STNAs, however there were only six. On 06/29/29 for day shift there were to be 11 STNAs, however there were only 6.7. For the night shift there were to be 11 STNAs, however there were only 4. The schedule revealed there were 3.2 nurses on day shift on 06/29/20. Interview on 06/30/20 at 11:40 A.M. with Registered Nurse (RN) #29 revealed she was responsible for medication administration for seven of the eight units at this facility on 06/29/20 during day shift. RN #29 revealed by the time she made it to B hall, it was way past morning administration time and was already time for noon medication to be administered. RN #29 confirmed the morning medications for the residents on the B hall, including Resident #22, #34, #98, #166, #184, #1, #30, #46, #72, #84, #102, #104, #132, #144, #158, #162 were not administered as there were not enough staff working to complete the medication administration timely and as ordered. During the interview, RN #29 revealed she had voiced this staffing concern to management at the beginning of the shift but no management licensed nurses provided her assistance with the medication administration. Further review of the staffing information for 06/29/20 day shift revealed in the East building there was an Agency nurse for A hall from 7:00 A.M. to 7:30 P.M. and RN #29 from 7:00 A.M. to 7:30 P.M. and then an agency LPN who came in from 4:30 P.M. to 7:30 P.M. In the West building there was supposed to be an Agency LPN, LPN #2, but this nurse called off and could not be replaced until 2:30 P.M. So this left just the East building agency nurse and RN #29 for all of these units also. This resulted in RN #29 being responsible for the administration of medication to residents on seven of the eight total nursing units for day shift. On 06/29/20 the facility indicated there were 114 total residents. This lack of staffing resulted in RN #29 being responsible to administer medications to 99 of 114 facility residents during the A.M./morning medication administration. Interview on 06/30/20 at 12:40 P.M. with Nurse Practitioner (NP) #1 revealed she comes into the facility about two to three times per week. NP #1 confirmed on 06/29/20 she observed RN #29 rushing around the facility and was informed the facility was short staffed that day. NP #1 revealed to try and help out with the staffing

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) issues, she would make sure when she was in a resident room she would try to offer the resident something to drink or eat. NP #1 confirmed the facility had been short staffed and indicated she thought it was related to COVID-19 and staff being afraid to come to work. During the interview, NP #1 did state she did not feel the facility being short staffed lately led to any harm to any of the residents or was the cause for any change in conditions that may have occurred with any residents. 2. Review of Resident #22's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #22's care plans from 02/19/16 through 09/09/20, revealed the resident exhibited behaviors of anger related to mental/emotional illness and had a psychosocial well-being problem with interventions including providing resident with ordered medication. Review of Resident #22's quarterly Minimum Data Set (MDS) 3.0 assessment, dated 06/01/20 revealed the resident required extensive assistance from one staff member for bed mobility, transfers, dressing and toilet use. Review of Resident #22's Medication Administration Record [REDACTED]. Review of Resident #22's nurse's note revealed a note dated 06/29/20 at 3:38 P.M. that indicated medications were not given (on this date) and the nurse practitioner was made aware. On 06/30/20 at 10:58 A.M. interview with the Director of Nursing (DON) revealed there had been many occurrences when she had been pulled to work the units as a nurse to administer medication due to lack of sufficient nursing staff. The DON verified there needed to be additional direct care staff members scheduled and working to meet the needs of the residents. Interview on 06/30/20 at 11:40 A.M. with Registered Nurse (RN) #29 revealed she was responsible for medication administration for seven of the eight units at this facility on 06/29/20 during day shift. RN #29 revealed by the time she made it to B hall, it was way past morning administration time and was already time for noon medication to be administered. RN #29 confirmed the morning medications, including those for Resident #22 were not administered as there were not enough staff working to complete the medication administration. Review of facility policy titled Medication and Treatment Orders, revised 07/2018 revealed orders for medication and treatments would be consistent with principals with safe and effective order writing. 3. Review of Resident #34's medical record revealed the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #34's quarterly MDS 3.0 assessment, dated 06/26/20 revealed the resident experienced disorganized thinking and an altered level of consciousness. Resident #34 required extensive assistance from one staff member for bed mobility and eating and total dependence from one staff member for dressing, toilet use and personal hygiene. Review of Resident #34's care plans, dated 06/26/20 through 07/10/20 revealed the resident had altered neurological status, a self care deficit and poor decision making skills. Resident #34 required tube feedings for nutrition and hydration support. Reveal of Resident #34's MAR, dated 06/29/20 revealed the following medications and nutritional supplement, Bumetaride (a diuretic to treat fluid retention), [MEDICATION NAME] (vitamin D3), Clopldogrel (blood thinner), [MEDICATION NAME] (for heart failure), [MEDICATION NAME] (for depression and anxiety), Pantoprazole (for [MEDICAL CONDITION] reflux disease) Potassium chloride (for low potassium levels), Carvedilol (for high blood pressure), [MEDICATION NAME] (a calorie dense nutritional supplement), [MEDICATION NAME] (a blood thinner), [MEDICATION NAME] acid (an anticonvulsant) and [MEDICATION NAME] (for anxiety), were all documented with a number 9 which indicated to please see nurses notes. Review of Resident #34's nurse's notes revealed a note, dated 06/29/20 at 4:20 P.M. that indicated medications not given (on this date) and the nurse practitioner was made aware. In addition, review of the facility shower schedule revealed Resident #34 was scheduled to receive a shower on Mondays and Thursdays on day shift. Review of Resident #34's shower sheets from June 2020 revealed no evidence the resident received a shower on 06/01/20, 06/04/20, 06/08/20, 06/11/20, 06/18/20 or 06/22/20 as planned. On 06/30/20 at 10:58 A.M. interview with the DON revealed there had been many occurrences when she had been pulled to work the units as a nurse to administer medication due to lack of sufficient nursing staff. The DON verified there needed to be additional direct care staff members scheduled and working to meet the needs of the residents. Interview on 06/30/20 at 11:40 A.M. with Registered Nurse (RN) #29 revealed she was responsible for medication administration for seven of the eight units at this facility on 06/29/20 during day shift. RN #29 revealed by the time she made it to B hall, it was way past morning administration time and was already time for noon medication to be administered. RN #29 confirmed morning medications, including those medications for Resident #34 had not been administered because there were not enough staff working. RN #29 continued to reveal there was many incidents when some of the residents did not receive their scheduled showers due to there not being enough direct care staff to provide this care. Interview on 06/30/20 at 1:00 P.M. with the Administrator revealed when a resident receives a shower, a shower sheet was to be completed and if there was not a shower sheet completed, then the resident did not receive a shower. Review of facility policy titled Medication and Treatment Orders, revised 07/2018 revealed orders for medication and treatments would be consistent with principals with safe and effective order writing. 4. Review of Resident #98's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #98's care plans, dated 01/17/20 through 07/29/20 revealed the resident had difficulty communicating, had a self care deficit and exhibited anxiety and behaviors of anger and yelling. Resident #98 was dependent on staff for activities, cognitive stimulation and social interaction and required tube feedings for nutrition and hydration support. Review of Resident #98's quarterly MDS 3.0 assessment, dated 04/15/20 revealed the resident had long and short term memory problems and an altered level of consciousness. Resident #98 required extensive assistance from two staff members for bed mobility and total dependence from staff for dressing, toilet use and personal hygiene. Reveal of Resident #98's MAR, dated 06/29/20 revealed the following medications and nutritional supplement, [MEDICATION NAME] (a patch for pain relief), [MEDICATION NAME] (a blood thinner), Polyethylene powder (a stool softener) [MEDICATION NAME] (a [MEDICAL CONDITION] drug), Chloraxidine (a topical antiseptic), Ensure plus (a nutritional supplement), [MEDICATION NAME] (a [MEDICATION NAME] and antacid) Senna [MEDICATION NAME] (a stool softener), [MEDICATION NAME] (a anticonvulsant and nerve pain medication) and [MEDICATION NAME] (for high blood pressure) were all documented with a number 9 which indicated to please see nurses notes. Review of Resident #98's nurse's note, dated 06/29/20 at 8:28 P.M. revealed medications were not given (on this date) and the nurse practitioner was made aware. On 06/30/20 at 10:58 A.M. interview with the DON revealed there had been many occurrences when she had been pulled to work the units as a nurse to administer medication due to lack of sufficient nursing staff. The DON verified there needed to be additional direct care staff members scheduled and working to meet the needs of the residents. Interview on 06/30/20 at 11:40 A.M. with Registered Nurse (RN) #29 revealed she was responsible for medication administration for seven of the eight units at this facility on 06/29/20 during day shift. RN #29 revealed by the time she made it to B hall, it was way past morning administration time and was already time for noon medication to be administered. RN #29 confirmed morning medication, including those for Resident #98 were not administered as there were not enough staff working to administer the medications timely. Review of facility policy titled Medication and Treatment Orders, revised 07/2018 revealed orders for medication and treatments would be consistent with principals with safe and effective order writing. 5. Review of Resident #184's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #184's care plans, dated 02/03/15 through 09/07/20 revealed the resident required assistance with all activities of daily living and all medications were to be administered as ordered. Review of Resident #184's quarterly MDS 3.0 assessment, dated 06/12/20 revealed the resident exhibited inattention and disorganized thinking. Resident #184 required extensive assistance from two staff members for bed mobility and total dependence from two staff members for dressing and personal hygiene. Reveal of Resident #184's MAR, dated 06/29/20 revealed the following medications, Aspirin (a blood thinner), Atorvastatin (for high cholesterol), [MEDICATION NAME] (a anticonvulsant) and [MEDICATION NAME] (a antidepressant) were all documented with a number 9 which indicated to please see nurses notes. Review of Resident #184's nurse's note, dated 06/29/20 at 7:01 P.M. revealed medications were not given (on this date) and the nurse practitioner was made aware. On 06/30/20 at 10:58 A.M. interview with the DON revealed there had been many occurrences when she had been pulled to work the units as a nurse to administer medication due to lack of sufficient nursing staff. The DON verified there needed to be additional direct care staff members scheduled and working to meet the needs of the residents. Interview on 06/30/20 at 11:40 A.M. with Registered Nurse (RN) #29 revealed she was responsible for medication administration for seven of the eight units at this facility on 06/29/20 during day shift. RN #29 revealed by the time she made it to B hall, it was way past morning administration time and was already time for noon medication to be administered. RN #29 confirmed morning medication on B hall, including those medications for Resident #184 were not administered as there were not enough staff working to administer the medications timely. Review of facility policy titled Medication and Treatment Orders, revised 07/2018 revealed orders for medication and treatments would be consistent with principals with safe and effective order writing. 6. Review of Resident #166's medical record revealed an original admission date of [DATE] and readmission date of [DATE]. The resident had [DIAGNOSES REDACTED]. Review of Resident #166's care plans, dated 10/08/19 through 08/25/20 revealed the resident had a self-care deficit related to neurocognitive disorder and required assistance with activities of daily living. Review of Resident #166's quarterly MDS 3.0 assessment,

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) dated 05/22/20 revealed the resident expressed inattention and disorganized thinking. Resident #166 required supervision from one staff member for bed mobility and extensive assistance from one staff member for dressing, toilet use and personal hygiene. Review of the facility shower schedule revealed Resident #166 was scheduled to receive a shower on Mondays and Thursdays on day shift. Review of Resident #166's shower sheets for June 2020, revealed no evidence the resident was provided a shower on 06/15/20, 06/18/20, 06/22/20, 06/25/20 or 06/29/20. Interview on 06/30/20 at 11:40 A.M. with Registered Nurse (RN) #29 revealed there were many incidents when some of the residents, including Resident #166 did not receive their scheduled showers due to there not being enough direct care staff to provide this care. Interview on 06/30/20 at 1:00 P.M. with the Administrator revealed when a resident receives a shower, a shower sheet was to be completed and if there was not a shower sheet completed, then the resident did not receive a shower. 7. The following staff and resident interviews obtained as part of the investigation also revealed concerns related to facility staffing: On 06/30/20 at 12:10 P.M. interview with Licensed Practical Nurse (LPN) #30 revealed she normally worked on the memory care units and they were normally staffed pretty well. However, the LPN was aware the other units in the facility needed more staff and they were always working short. On 06/30/20 at 12:30 P.M. interview with LPN #91 revealed the facility needed additional direct care staff members to properly care for each resident. On 07/06/20 at 9:18 A.M. interview with Resident #196 revealed there had been a few times (dates not provided) when her call light had been on for a long period of time due to the facility being short staffed. During the interview, the resident stated she had also over heard staff members talk about being short staff and not having enough help. On 07/06/20 at 9:25 A.M. interview with Resident #21 revealed she has turned on her call light and had to wait long periods of time for it to be answered due to the facility being short staffed. On 07/06/20 at 9:40 A.M. interview with State tested Nursing Assistant (STNA) #92 revealed there were not enough direct care staff members working the floor to provide proper care for the residents and there were times when showers did not get completed due to short staffing. This deficiency substantiates Master Complaint Number OH 791 and Complaint Number OH 700.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview and policy review the facility failed to ensure Resident #196's medical record was complete and accurate related to the use of a bilevel positive airway pressure ([MEDICAL CONDITION]) machine. This affected one resident (#196) of three residents reviewed for accuracy of medical record documentation. Findings include: Review of Resident #196's medical record revealed an initial admission date of [DATE] and a readmitted d of 06/13/20. The resident had [DIAGNOSES REDACTED]. Review of Resident #196's care plans, dated 01/18/17 through 06/06/20 revealed the resident had altered respiratory status and difficulty in breathing related to chronic [MEDICAL CONDITION]. Interventions included administration of medication and puffer as ordered and to apply ordered [MEDICAL CONDITION] at ordered settings. Review of the physician's orders [REDACTED]. Review of the Treatment Administration Record (TAR) for June 2020 revealed the resident's [MEDICAL CONDITION] was documented as being provided every night shift. Review of Resident #196's discharge-return anticipated Minimum Data Set (MDS) 3.0 assessment, dated 06/09/20 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 06 with short term memory problems. The MDS did not include any indication of medication or treatments refusals. Interview on 07/06/20 at 9:16 A.M. with Licensed Practical Nurse (LPN) #28 revealed Resident #196 liked to watch television at night time and when she wears her [MEDICAL CONDITION] it makes it difficult to see the television so when staff go into her room to apply the Bi-Pap mask she requests to wait until she was finished watching television. LPN #28 also revealed most of the time Resident #196's [MEDICAL CONDITION] was never applied either due to staff forgetting to apply the mask or due to the resident saying up all night. LPN #28 confirmed Resident #196's order for a [MEDICAL CONDITION] to be applied every night was documented as being administered. Interview on 07/06/20 at 9:25 A.M. with Resident #196 revealed she liked to stay up all night to watch television and when she had the ([MEDICAL CONDITION]) mask on it makes it hard to see the television. Resident #196 confirmed most of the time, she does not have her mask on at all throughout the day or night. Interview on 07/06/29 at 3:30 P.M. with Registered Nurse (RN) #38 revealed there was a night shift she was working with another nurse and asked the other nurse to show her how to properly apply the resident's [MEDICAL CONDITION] mask. The other nurse informed RN #38 she did not know how to apply the mask because she had never done it, but just checked it off on the TAR as being completed. Review of policy titled Administration and Documentation with a revision date of 07/2018 revealed documentation must be completed of medications/treatments not administered as ordered, with a circle on the administration record and explanation of the reason why the medication was not administered. This deficiency substantiates Master Complaint Number OH 791.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, record review and interview the facility failed to ensure cleaning supplies were readily accessible to staff to ensure proper infection control measures were maintained to prevent the spread of infection. This had the potential to affect all 64 residents residing in the West Building. The facility census was 105. Findings include: 1. On 06/30/20 beginning at 10:00 A.M. a tour of the facility West building revealed a medication storage room located at the nurse's station with an empty cleaning spray bottle. The bottle was an all purpose cleaner and disinfectant. On 06/30/20 at 12:32 P.M. during an interview with Licensed Practical Nurse (LPN) #91, the LPN revealed the West building does not get cleaned on a regular basis by housekeeping staff and there was a spray bottle with liquid cleaner located in the nurse's medication storage room that had been empty for days. The LPN revealed this was the cleaner that nursing staff were expected to use to clean the nurse's station. During the interview LPN #91 revealed she was told (by an unnamed person) to use this cleaner to clean the nurse's station throughout the day. LPN #91 claimed she informed housekeeping staff multiple times the bottle was empty and they were the ones who were to refill it and they never did. LPN #91 claimed the bottle was empty before she was off work for three days and when she returned, the bottle was still empty and when she asked the other nurses they all said it was never filled. On 06/30/20 at 12:40 P.M. interview with the Administrator confirmed the spray bottle in the nurse's medication storage room was empty and was to be used for cleaning and disinfecting surfaces. On 07/06/20 at 9:42 A.M. observation revealed the West building nurse's station medication room had an empty spray bottle of cleaning solution. On 07/06/20 at 9:44 A.M. interview with LPN #91 confirmed the cleaning spray bottle continued to be empty and stated it had been empty for days. Review of the policy titled Infection Prevention and Control Program, with a revision date of 02/2019 revealed the facility had developed and maintained an Infection Control Program that would provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 2. Observation on 07/06/20 at 9:30 A.M. revealed a three shelved cart used to transport liquids for meals located on hall C. The second and third shelves of the cart were observed to be covered with dried dark brown substances. On 07/06/20 at 9:35 A.M. State tested Nursing Assistant (STNA) #92 confirmed this cart, used to transport liquids during meal times was visibly soiled with dried liquids and food. STNA #92 revealed she believed it was the responsibility of dietary staff to clean the cart when it was returned to the kitchen. Review of the policy titled Infection Prevention and Control Program, with a revision date of 02/2019 revealed the facility had developed and maintained an Infection Control Program that would provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This deficiency substantiates Complaint Number OH 791.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, record review and staff interview this facility failed to maintain the resident environment in the West building B hall (COVID-19 isolation unit) in a clean and sanitary manner. This had the potential to affect 16 residents, Resident #22, #34, #98, #166, #184, #1, #30, #46, #72, #84, #102, #104, #132, #144, #158, #162 who resided in the West building on the B hall. The facility census was 105. Findings include: On 06/30/20 beginning at 10:00 A.M. a tour of the West building revealed environmental concerns on the B Hall. The hallway floor and resident room floors were observed to have a build up of dirt and dried and wet liquids in various locations throughout the hallway. In addition, there were used cotton balls, used accu-check strips and empty medication cups on the floor. There was dirt, food, cotton

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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 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) balls, accu-check strips, dried yellow areas on the floor and dried red liquid which appeared to be juice. This was noted in the entire B hallway and in each of the residents rooms. There was not a room on the hall that did not have something on the floor. The facility identified 16 residents, Resident #22, #34, #98, #166, #184, #1, #30, #46, #72, #84, #102, #104, #132, #144, #158, #162 who resided in the West building on the B hall. On 06/30/20 at 12:32 P.M. interview with Licensed Practical Nurse (LPN) #91 revealed there were days when housekeeping staff did not provide any housekeeping services on the West building B Hall. At the time of the interview, LPN #91 confirmed the condition of the B hall floors in the hallway and resident rooms as noted above. On 06/30/20 at 12:40 P.M. interview with the Administrator confirmed the B hall needed to be cleaned and there was dirt and debris in the hallway and in the resident's rooms. The Administrator revealed the facility currently did not have a cleaning schedule for housekeeping staff to follow. On 06/30/20 at 12:45 P.M. interview with Housekeeper #1 revealed she was the only housekeeper for the West building on this date. She stated there were supposed to be two housekeepers but she had not seen another housekeeper at all on this date. Housekeeper #1 revealed she was responsible for half of the West building, Halls A and D. The Housekeeper revealed the other housekeeper never showed up and when she was done with the A and D hall she would clean the C hall, but would not clean the B hall because it was the COVID-19 isolation hall. Review of the policy titled Infection Prevention and Control Program with a revision date of 02/2019 revealed the facility had developed and maintained an Infection Control Program that would provide a safe, sanitary and comfortable environment. This deficiency substantiates Complaint Number OH 791.