STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366047	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RAE ANN GENEVA	839 W MAIN STREET GENEVA, OH 44041

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, interview and record review, the facility failed to ensure proper storage and handling of clean resident linens. This had the potential to affect all 64 residents currently residing in the facility. Findings include: Observation on 03/09/20 at 8:14 A.M. during initial tour of the facility revealed a clean linen cart located on the Northern Lights hallway next to the door of room [ROOM NUMBER] with the linen cart's cover draped over the top and partially behind the linen cart. The clean linen cart was observed to contain various resident linens and supplies which included: towels, washcloths, resident gowns, blankets and unused incontinence briefs. A covered hot beverage cup with liquid inside was observed sitting on the top shelf inside the linen cart next to clean linen. Interview on 03/09/20 at 8:15 A.M. with Housekeeping #207 confirmed the clean linen cart observed on the Northern Lights hallway was stocked with resident linens and supplies. She verified a covered hot beverage cup with liquid inside was sitting inside the cart next to the clean linen, and the clean linen cart was not covered. She indicated the hot beverage cup should not be inside the clean linen cart and the clean linen cart should always be covered. Observation on 03/09/20 at 8:17 A.M. during initial tour of the facility revealed a clean linen cart located on the Concord Hall hallway next to the door of room [ROOM NUMBER] with the linen cart's cover draped over the top and partially behind the linen cart. The clean linen cart was observed to contain various resident linens and supplies which included: towels, washcloths, resident gowns, blankets and unused incontinence briefs. Interview on 03/09/20 at 8:18 A.M. with State tested Nursing Assistant (STNA) #228 confirmed the clean linen cart observed on the Concord Hall hallway was stocked with resident linens and supplies and confirmed the clean linen cart was not covered. She indicated the clean linen cart should always be covered. Interview on 03/09/20 at 8:19 A.M. STNA #267 confirmed the clean linen cart observed on Northern Lights hallway was not covered as required, and the hot beverage cup with liquid inside was hers and was sitting inside the cart next to the clean linen. She indicated staff were not permitted to have beverages in resident care areas or inside clean linen carts. Interview on 03/09/20 at 9:02 A.M. with Housekeeping #202 verified all clean linen carts are placed into the clean linen room when not in use and taken out of that room to the needed resident care areas. She confirmed clean linen carts were to be covered to prevent cross contamination and staff were not permitted to have beverages in resident care areas or inside clean linen carts. Interview on 03/09/20 at 10:48 A.M. with Registered Nurse (RN) #271 verified facility staff were inserviced on 02/14/20 about clean linen carts were to be covered at all times, and confirmed staff were not permitted to have beverages in resident care areas or inside clean linen carts. Interview on 03/09/20 at 11:14 A.M. with Director of Nursing (DON) confirmed clean linen carts were to be covered and staff were not permitted to have beverages in resident care areas or inside clean linen carts. Interview on 03/09/20 at 1:34 P.M. with Licensed Practical Nurse (LPN) #251 confirmed clean linen carts were to be covered and staff were not permitted to have beverages in resident care areas or inside clean linen carts. Interview on 03/09/20 at 1:46 P.M. LPN #219 confirmed clean linen carts were to be covered and staff were not permitted to have beverages in resident care areas or inside clean linen carts. Interview on 03/09/20 at 2:03 P.M. STNA #200 verified clean linen carts were stored in the clean linen room and taken out to areas when needed. She confirmed clean linen carts were to be covered and staff were not permitted to have beverages in resident care areas or inside clean linen carts. Interview on 03/09/20 at 2:32 P.M. with STNA #269 verified clean linen carts were stored in the clean linen room and taken out to areas when needed. He confirmed clean linen carts were to be covered and staff were not permitted to have beverages in resident care areas or inside clean linen carts. Review of facility inservice entitled, Survey Readiness, conducted by Administrator on 02/14/20 for all staff, revealed Carts can be out during AM and HS care but they cannot be stored in hallways. Anything over 30 minutes is considered 'stored'. The covers are to remain down at all times, no personal effects are allowed on the linen carts.

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.