STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365578	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKLD NEW LEXINGTON ILLUMINATE HC NEW LEXINGTON	920 SOUTH MAIN STREET NEW LEXINGTON, OH 43764

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** - Some	**Provide and implement an infection prevention and control program.** Based on observation and staff interview the facility failed to maintain clean and sanitary linen storage and infection control practices to provide a safe and sanitary environment on the COVID-19 unit. This had the potential to affect all ten residents (#2, #9, #15, #30, #31, #32, #38, #44, #46 and #47) residing on the COVID-19 unit. The facility census was 57. Findings include: On 08/24/20 at 12:30 P.M. observation during tour of the COVID-19 unit revealed the following: In the soiled room where staff removed (doff) their personal protective equipment (PPE), there was a toilet brush laying out on the floor, not stored in a holder. A supply room was being used as a nurse's station as well as storage room. A linen cart, located in the room was not covered leaving resident linen open to contamination. There were two cardboard boxes and one plastic tote sitting directly on the floor. These boxes contained various medical supplies with some rolls of strap type material hanging out and resting directly on the floor. The medication cart was also stored in this room and on top of the cart was a container of applesauce used to administer medications. The applesauce was open and not covered or dated and sitting next to disinfectant wipes and a bottle of skin and hair soap leaving it open to contamination. On 08/24/20 at 12:45 P.M. interview with Licensed Practical Nurse (LPN) #2 confirmed the above findings. The LPN threw the applesauce away as well as the hair and skin soap stating he didn't know who they belonged to. The LPN also confirmed the toilet bowl brush was on the floor and stated they had another one in the bathroom they could use. He stated he would call someone to get the linen cart covered. On 08/24/20 at 1:30 P.M. interview with the administrator revealed she was aware of the toilet brush and stated they didn't have a holder to put it in and were not using it. She stated the nursing staff were responsible for all housekeeping/cleaning duties on the unit during the COVID-19 pandemic due to trying to limit the number of staff working on the unit. The administrator revealed the facility would have to come up with some way to monitor for infection control related to these areas and indicated possibly a virtual audit of the hall. This deficiency is an example of continued non-compliance from the survey dated 08/04/20.
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 and staff interview, the facility failed to ensure a safe environment for residents when the medication cart on the COVID-19 unit also noted as 1 back hall was left unattended and unlocked and two oxygen tanks were noted, one in the soiled room and one in the nurses station/supply room that were not secured in either a cart or secured to the wall to prevent them from tipping over. This had the potential to affect 10 residents (#2, #9, #15, #30, #31, #32, #38, #44, #46 and #47 residing on the COVID-19/1 back hall unit. The facility census was 57. Findings include: On 08/24/20 at 12:30 P.M. observation revealed the medication cart stored in the nurse's station/supply room was left unlocked and unattended with the door open. Two oxygen tanks were also observed stored, one in the soiled room and another in the nurse's station/supply room that were sitting on the floor unsecured in a manner to keep them from tipping over. Neither tank was in a cart or secured to the wall. On 08/24/20 at 12:50 P.M. interview with Licensed Practical Nurse (LPN) #2, who was coming out of a resident room, verified the medication cart was left unattended and was unlocked and the oxygen tanks were not stored safely/correctly. The LPN revealed he would call and get carts for the oxygen tanks.

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.