STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366068	A. BUILDING _____ B. WING _____	**06/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORCHARD VILLA	**2841 MUNDING DRIVE OREGON, OH 43616**

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, staff interview, review of facility policy, and review of the Centers for Disease Control and Prevention (CDC) recommendations, the facility failed to follow infection control guidelines to mitigate the transmission of COVID-19 when their staff was found wearing the same personal protective equipment between residents with an unknown COVID 19 status on the facility quarantine unit. This had the potential to affect 17 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17) who resided in the facility's designated quarantine unit. The facility census was 100. Findings include: Interview on 06/29/20 at 3:41 P.M., with Licensed Practical Nurse (LPN) #25 revealed she must wear full personal protective equipment (PPE) while in the building. LPN #25 stated the required PPE included face mask, face shield, gown, gloves, and a hair covering. LPN #25 stated she wore the same PPE the entire shift to care for all her residents unless they were on transmission-based precautions or the PPE became soiled. LPN #25 stated if a resident was placed in transmission-based precautions there would be a sign on the resident's door and an additional bin of PPE outside of the resident room. LPN #25 stated she would then don a second gown over top of the one she was already wearing to care for the resident, remove it before leaving the room, and return to the community in the original gown she was wearing. Interview 06/29/20 3:54 P.M., with the Director of Nursing (DON) revealed the facility has one quarantine zone that they use to house new admissions, readmissions, and residents who are returning from outside appointments. The facility also has a separate isolation unit for confirmed cases of COVID-19. DON stated the residents in the quarantine unit are to stay on the unit for 14 days. DON stated the quarantine zone uses designated staff that remain in that area for the entire shift. While in the quarantine zone the staff members follow wear the same face facemask, face shield, gown, gloves, and hair covering for the entire shift while caring for all residents on the unit, unless a resident is placed is in transmission-based precautions, or the PPE that is being worn becomes soiled or unusable. Per DON, any resident who is placed in transmission-based precautions would require a second gown and a second facemask to be placed over the top of the original PPE the staff member has on. Observation on 06/30/20 at 9:38 A.M., during a tour of the facility quarantine unit with the Administrator and DON revealed one unidentified staff member who walked down the hallway that houses resident Rooms 201-210. The staff member then walked into a resident room without stopping outside the room to don any additional PPE or change the current PPE being worn. Interview at this time with the Administrator and DON verified the quarantine zone included two halls. Hall one included Rooms 201-210. Hall two included Rooms 234-243. Review of the facility policy titled COVID 19 Transmission-Based Precautions, dated 06/09/20, revealed staff are to utilize PPE when providing care for all residents in the facility if a positive COVID-19 resident resides in the building, which includes mask, eye protection, gowns, gloves, shoe covers, and hair nets if available. The policy also stated when extended use of gowns are used, the same gown by the same healthcare worker is permitted while interacting with multiple residents with the same known infectious disease (COVID-19). Review of the Centers for Disease Control and Prevention Recommendations for Nursing Homes and Long-Term Care Facilities, dated 06/25/20, revealed if extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections (e.g., Clostridioides difficile). The facility identified 17 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17) who resided in the facility's designated quarantine unit.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE