STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366073	A. BUILDING _____ B. WING _____	10/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SWANTON HEALTH CARE RETIREMENT	214 S MUNSON RD SWANTON, OH 43558

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 03/13/20, review of guidance from the Centers for Disease Control (CDC) and Prevention website related to preparing for Coronavirus Disease 2019 (COVID-19) and responding to COVID 19 for nursing homes and health care facilities, surveyor observations, medical record reviews, staff interviews, review of the facility census sheet which included a detailed record of the residents COVID 19 status and location in the building, review of facility infection control line listing for COVID-19 testing of residents, review of the policy for considerations for cohorting COVID-19 residents in post-acute care facilities, the facility failed to implement effective and recommended infection control practices to prevent the spread of COVID-19 including: ensuring residents were cohorted correctly in accordance with facility policy following COVID-19 outbreak testing and ensuring Personal Protective Equipment (PPE) was changed between care of residents who were quarantined for exposure to COVID-19. This resulted in Immediate Jeopardy for nine residents (#01, #02, #03, #04, #05, #06, #07, #08, #09) who were COVID-19 negative and remained on the COVID-19 positive unit. The nine residents later tested positive for COVID-19. Additionally, four residents (#10, #11, #12, #13) who were negative for COVID-19 and quarantined for exposure to COVID-19, were placed in Immediate Jeopardy when staff members provided care without changing PPE between each resident. The facility census was 57. On 10/05/20 at 4:58 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on 09/28/20 when the facility failed to move residents in accordance with their policy and the latest CDC guidelines dated 06/25/20, after receiving results for COVID-19 initial outbreak testing. On 09/28/20, the facility was informed 34 residents and 23 staff members had tested positive for COVID-19. After receiving the results on 09/27/20, the facility began setting up designated units to separate positive and negative cases and completed the movement of residents on 09/28/20. On 10/01/20, nine residents who were negative for COVID-19 continued to reside on the positive COVID-19 unit. Seven of the nine identified residents had a roommate who was positive for COVID-19. Observations were made of staff in the positive COVID-19 unit providing direct care to both positive and negative residents wearing the same PPE between all residents. On 10/02/20, the facility received the results of their second round of outbreak testing. The nine identified residents who had previously been negative were found positive for COVID-19. The Immediate Jeopardy continued 10/05/20 when four residents in the quarantine unit were provided direct care by staff without changing PPE between the four residents. The quarantine unit was designated by the facility for residents who were negative for COVID-19 but exposed to [MEDICAL CONDITION]. The quarantine unit included two rooms with double occupancy. Both double occupancy rooms had two residents in each room. Staff were instructed by the facility to provide care to residents who were quarantined in the same room while wearing the same PPE between residents. The Immediate Jeopardy was removed on 10/06/20 at 5:35 P.M. when the facility established three separate units; one for negative residents, one for positive residents and one for quarantined residents, based on the residents COVID-19 status, changed the facility practice pertaining to PPE when caring for quarantined residents, and initiated a COVID-19 policy for cohorting residents. The deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) until it was corrected on 10/21/20 when the facility implemented the following corrective actions: On 09/27/20, the facility started receiving COVID-19 laboratory results from the testing performed on 09/24/20, with results continuing through 09/28/20. Based on the testing, 30 of 54 residents were identified as positive for COVID-19, 13 of 54 residents were identified as negative but exposed to COVID-19, and 11 of 54 residents were found to be negative and not exposed. Additional PPE stations were made available throughout the unit. On 09/28/20, the facility activated the Congregate Care Unified Response Team (CCURT) with a telephone call to Team Member #25. The coordinated call took place at 4:30 P.M. On 09/28/20, all guidance provided was followed and calls were placed to recommended staffing agencies. The Ohio National Guard was activated and responded to immediate staffing needs with response in place by 8:30 P.M. On 10/01/20, the laboratory results were received for testing performed on 09/29/20. Resident rooms were cleaned and sanitized to prepare for room moves based on CDC guidelines requiring 12-24 hours between sanitation and resident move in. Barrier walls were constructed to isolate negative and not exposed residents from the rest of the population. Additional PPE stations were made available throughout all units. On 10/02/20, resident room moves were made to accommodate cohorting of residents as a result of the 09/24/20 and 09/29/20 laboratory results. Barrier walls applied to all negative but exposed rooms. Additional PPE stations were made available throughout all units. All resident records were reviewed by the DON, Infection Preventionist (IP) #50, Minimum Data Set (MDS) Nurse #15 and the Administrator to accommodate necessary room changes. On 10/03/20, resident room changes were made to accommodate additional residents identified as positive and negative but exposed from testing on 09/29/20. Based on the room moves 43 of 57 residents were identified as positive for COVID-19 and cohorted on identified COVID positive unit; Seven of 57 residents were identified as negative but exposed to COVID-19 and cohorted on a negative but exposed unit and seven of 57 residents tested were found to be negative and not exposed and cohorted in a negative and not exposed unit. Zipper barriers were applied to the entrances of all rooms housing negative but exposed residents. Additional PPE stations were made available throughout all units. All changes mentioned under this paragraph were completed by the DON, Social Services Director #10, and Housekeeping Supervisor #55. On 10/05/20, the DON and Administrator revised the policy on PPE usage in cohorted negative but exposed rooms. Staff education began on 10/05/20 and continued on 10/06/20, when all staff were educated on the revised policy for PPE usage in cohorted negative but exposed rooms. All staff education was via one or more of the following formats: text, email, phone calls, Relias training, and On shift. Staff will not be permitted to work without receipt of acknowledgment regarding education. PPE equipment was placed inside and outside of all rooms with cohorted residents testing negative but exposed. PPE usage audits were being completed daily on varying shifts for four weeks. Retesting of all previously negative staff and residents is to be completed on 10/06/20, and then weekly thereafter. Interviews on 10/20/20 from 11:35 A.M. to 11:39 A.M. with Licensed Practical Nurse (LPN) #60, and State tested Nurse Aide ' s (STNA) #70 and #80, verified they had received in-service education on PPE usage via computer and in-person. The topics covered were the type of PPE to be utilized when on the quarantine and the COVID-19 units. Review of the facility audit records for PPE usage from 10/06/20 to 10/19/20 verified one audit was completed by the Infection Preventionist or designee each day during the period reviewed. No concerns were identified. Review of the facility COVID-19 testing records for 10/06/20 and 10/13/20 verified all staff and residents in the facility had been tested . Findings include: Review of the facility census sheet which included a detailed record of the residents COVID-19 status and location in the building dated 09/28/20, revealed the facility had set up a designated COVID-19 negative area in the 300 unit. All other units of the building (units 100 and 200) were dedicated to positive residents. Nine Residents (#01, #02, #03, #04, #05, #06, #07, #08, #09) who were identified COVID-19 negative on the bed board remained in units 100 or 200 as of 09/28/20. The bed board dated 10/01/20, revealed the nine identified residents continued to reside in the same rooms they occupied on 09/28/20. Seven residents (#01, #04, #05, #06, #07, #08, #09) of the nine negative residents were identified on both the 09/28/20 and 10/01/20 bed board as having a roommate who was confirmed positive for COVID-19. The

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.

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) 09/28/20 and the 10/01/20 bed board were absent for evidence of any additional units being set up for residents with a negative testing status who were exposed to COVID-19. The bed board dated 10/02/20, revealed Residents (#01, #02, #03, #04, #05, #06, #07, #08, #09) were all confirmed positive for COVID-19. The bed board dated 10/02/20, revealed the facility had set up a quarantine unit for COVID-19 negative but exposed residents which was located at the end of the 200-unit hallway. The bed board from 10/03/20 revealed four residents (#10, #11, #12, #13) tested negative for COVID-19 but were quarantined for an exposure. The 10/03/20 bed board also identified Residents #10 and #11 as roommates and Residents #12 and #13 as roommates. Review of the COVID-19 Outbreak Line Listing, revealed the facility had completed two rounds of COVID-19 outbreak testing. Initial outbreak testing for all residents took place on 09/24/20, and all results were received by the facility on 09/28/20. The results of testing concluded 34 residents were positive for COVID-19. The second round of testing for all residents was conducted on 09/29/20 and results were reported to the facility on [DATE]. The results indicated an additional 10 residents were positive for COVID-19, bringing the facility total to 43 residents. The line listing verified Residents #01, #02, #03, #04, #05, #06, #07, #08, and #09 had initially tested negative during the first round of testing, then tested positive for COVID-19 during the second round of testing. Interview on 10/01/20 at 9:25 A.M. with the Executive Director (ED), revealed the facility was notified on 09/24/20 that a resident who had been transferred to the hospital had tested positive for COVID-19. The ED stated the facility began outbreak testing protocol and began testing all residents and staff that same day. The results of the testing were reported to the facility on [DATE] and all results were received by 09/28/20. The results indicated 34 residents and 23 staff members were positive for COVID-19. The ED stated after receiving the test results, the staff separated negative residents from positive residents by creating dedicated units and residents were moved based on the test results. The ED confirmed the facility had finished the movement of residents to their dedicated areas on 09/28/20. Interview on 10/01/20 at 9:38 A.M. with IP #50, revealed the facility had set up two units in the building to separate their positive and negative COVID-19 cases. The negative COVID-19 unit was in the 300 unit and separated by a plastic barrier in the hallway. The residents on this unit had a negative testing status and did not have any exposure to COVID-19. IP #50 stated the 100 and 200 units were designated for positive residents but also housed residents who were tested negative but exposed to COVID-19. IP #50 stated residents with an exposed status were presumed positive and deemed safe to isolate with residents with a positive COVID-19 status. Observation on 10/01/20 between 9:25 A.M. and 9:45 A.M., during an initial tour, revealed all clinical staff in the facility were wearing an N95 masks, a face shield or goggles, and isolation gowns throughout the building. Review of the medical record for Resident #01 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Further review of the medical record revealed Resident #01 received two COVID-19 tests. The results of the initial COVID-19 test collected on 09/24/20, was reported to the facility on [DATE], and was negative. Results of a second COVID-19 test collected on 09/29/20, was reported to the facility on [DATE] at approximately 11:47 P.M. and was positive. Resident #01 shared a room with Resident #15. Review of the medical record for Resident #15 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Further review of the medical record revealed Resident #15 had received a COVID-19 test on 09/24/20. The results of the test were positive and reported to the facility on [DATE]. Review of the medical record for Resident #04 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Further review of the medical record revealed Resident #04 received two COVID-19 tests. The results of the initial COVID-19 test collected on 09/24/20, was reported to the facility on [DATE] and was negative. Results of a second COVID-19 test collected on 09/29/20 and reported to the facility on [DATE] was positive. Observation on 10/01/20 at 12:05 P.M. in the 100 unit of the building revealed State tested Nursing Assistant (STNA) #20 entered the room of Resident #01 who was negative, and Resident #15 who was positive, wearing an N95, goggles, isolation gown, and gloves. STNA #20 began assisting Resident #15 with moving her tray table and call light near the resident and adjusting the blankets on the resident ' s bed. STNA #20 then went to the bedside of Resident #01 and began to assist the resident with eating. STNA #20 did not perform hand hygiene or change any of the PPE she was wearing between care of the two residents. Interview on 10/01/20 at 12:23 P.M. with STNA #20, revealed she was assigned to the 100 unit and four rooms on the 200 unit that day. STNA #20 verified while caring for Resident #01 and Resident #15, hand hygiene was not performed, and PPE was not changed between the residents. STNA #20 stated she had not changed the N95, goggles, or isolation gown she was wearing at all since she arrived for her shift that morning. STNA #20 stated she was instructed to wear the same PPE for the entire shift while caring for all residents unless the PPE became soiled or damaged. Observation on 10/01/20 at 12:33 P.M. in the 100 unit of the building, revealed LPN #30 entered room [ROOM NUMBER] wearing an N95, a face shield, and isolation gown. LPN #30 assisted Resident #14 with adjusting the blankets on the bed and obtaining personal items from the tray table. LPN #30 then exited the resident ' s room wearing the same PPE she entered with and continued back to her medication cart in the hallway where she performed hand hygiene. At approximately 12:37 P.M., LPN #30 entered Resident #04 ' s room wearing the same N95, face shield, and isolation gown she had worn in Resident #14 ' s room. LPN #30 assisted Resident #04 with taking a drink and placing the call light beside the resident. During an interview with LPN #30 on 10/01/20 at 12:40 P.M. she stated her assignment that day was the 100 unit and two rooms on the 200 unit. LPN #30 verified she had been wearing the same PPE throughout her shift between all residents and was told only to change it if it became soiled or damaged. LPN #30 also stated she was aware residents in her care were both negative and positive for COVID-19 but was told by the management team to maintain the same PPE she had on between all residents. Interview with IP #50 on 10/01/20 at 2:35 P.M., confirmed staff assigned to the 100 and 200 units were utilizing the same PPE for the duration of their shift in order to conserve supply. IP #50 verified staff were instructed to wear the same PPE between all residents including those who ' s COVID-19 status was negative but remained on the COVID-19 positive unit. Review of the list of residents in transmission-based precautions dated 10/05/20, provided by the facility, revealed Residents #10, #11, #12, and #13, were in droplet isolation precautions. Observation on 10/05/20 at 12:35 P.M., of the facility ' s quarantine area designated for residents exposed to COVID-19, revealed isolation bins with PPE supplies were located outside of each resident room. Signs were posted on each resident door in the quarantine area regarding transmission-based precautions. The signs stated staff were to don a clean gown, facemask, and gloves prior to providing care for residents in those rooms. Interview with LPN #60 on 10/05/20 at 3:57 P.M., revealed her assignment for that day included the area dedicated to residents quarantined for exposure to COVID-19. LPN #60 stated the required PPE for residents who were exposed and in quarantine was an N95, isolation gown, gloves, and eye protection. LPN #60 stated when caring for quarantined residents who were together in the same room, she was wearing the same PPE between both residents. LPN #60 stated it was her understanding that once she donned the proper PPE prior to entering the room, she was considered clean and could provide care to both residents without changing PPE between them. LPN #60 verified there were two rooms on the quarantine unit that had double occupancy. LPN #60 verified Residents #10 and #11 were roomed together and Residents #12 and #13 were roomed together with the same COVID-19 exposure status. Interview with the DON on 10/05/20 at 4:40 P.M., verified the staff were told that when caring for residents in quarantine with a negative test result and exposure that were in the same room, the same PPE could be used between both residents because both residents had already been exposed to COVID-19. Review of the facility policy titled, Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities dated 08/03/20, revealed the plan for cohorting residents during an outbreak of COVID-19 indicated four different cohorts. Cohort #1 was for COVID-19 positive residents, Cohort #2 for COVID-19 negative but exposed residents, Cohort #3 for COVID-19 negative and not exposed residents, and Cohort #4 for new admissions and readmissions. The policy indicated Cohort #1 was to consist of both symptomatic and asymptomatic residents who test positive for COVID-19. Cohort #1 was to be on a separate closed unit if feasible. Cohort #2 was to consist of symptomatic and asymptomatic residents who test negative for COVID-19 with an identified exposure to someone who was positive. Exposed individuals would be quarantined for 14 days regardless of the test results. The guidelines for Cohort #2 stated residents who test negative for COVID-19 could be incubating and later test positive. Cohort #3 would consist of residents who test negative for COVID-19 with COVID-19 like symptoms and were thought to have no known exposures. Review of the CDC website COVID-19 guidelines titled, Use of Testing to Inform the Response to COVID-19 in Nursing Homes (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html), dated 04/30/20, revealed if testing capacity allows use of facility wide testing following identification of newly identified [DIAGNOSES REDACTED]-CoV-2 infected residents or healthcare personal could be particularly important. Facility wide testing can help identify a symptomatic or pre-symptomatic resident with COVID-19 to guide movement into COVID-19 designated spaces. Review of the CDC website COVID-19 guidelines titled, Infection Control for Nursing Homes(https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html) dated 06/25/20, revealed when extended use of gowns was implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it was for the care of residents with confirmed COVID-19 who were cohorted in the same area of the facility and these

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) residents were not known to have any co-infections (e.g., Clostridioides difficile). Further review of this section of the CDC revealed the facility should have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of Transmission-Based Precautions, prioritize for testing, transfer to COVID-19 unit if positive) and have a plan for how roommates, other residents, and HCP who may have been exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them). Review of the CDC website COVID-19 guidelines titled, Responding to COVID-19, dated 04/30/20, revealed responding to residents newly infected with [DIAGNOSES REDACTED]-CoV-2 includes ensuring the resident was isolated and cared for using all recommended COVID-19 PPE. The resident should be placed in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing. Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit). If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission.