STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366097	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FULTON MANOR NURSING & REHAB C	723 SOUTH SHOOP AVENUE WAUSEON, OH 43567

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 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and review of the facility's policy, the facility failed to ensure a resident had privacy during incontinence care. This affected one (Resident #18) of one resident reviewed for privacy. The facility census was 64. Findings include: Review of Resident #18's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment, dated 12/26/19, revealed the resident was moderately cognitively impaired. He was dependent upon staff for transfers and toileting and was frequently incontinent. Review of the care plan, dated 06/15/17, revealed the resident required assistance with activities of daily living (ADLs) due to physical limitations related to difficulty with walking and generalized weakness. Resident #18 required assistance with elimination due to being incontinent and was unable to use the toilet himself. Observation on 03/02/20 at 1:02 P.M. revealed Resident #18 and #20 shared the same room number and their rooms were set up like a jack-and-jill style bathroom that leads into each other's side of the room. During an interview with Resident #20, Resident #18 was observed laying on his right side with his shirt slightly pulled up and his pants pulled down while State-tested Nurse Aides (STNA) #429 and #440 provided incontinence care. Resident #18's door was closed, however his privacy curtain located between Resident #18's room and his roommate's room (Resident #20) was not pulled and Resident #18's buttocks could be seen from Resident #20's side of the room. Interview on 03/02/20 at 1:03 A.M. with STNA #429 verified Resident #18's privacy curtain was not closed while Resident #18 received incontinence care. Review of the facility's undated policy titled, Residents Rights and Dignity Issues, revealed privacy curtains are used to ensure the resident's privacy.
F 0812 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, staff interview and review of the facility's policy, the facility failed to ensure garbage cans were covered with lids when not in use. In addition, the facility failed to ensure trays were distributed in a safe and sanitary manner. This had the potential to affect all 64 of 64 residents who receive food from the kitchen. Findings include: Observation on 03/02/20 at 8:51 A.M. revealed there were four trash cans located in the main kitchen were uncovered and trash was exposed. No lids were available and the trash cans were not in use. Interview on 03/02/20 at 8:56 A.M. with Dietary Manager #515 verified the lids were not used to cover the trash cans. Dietary Manager #515 further explained lids were not utilized because staff would touch them often and would have to wash and re-glove their hands. Observation on 03/02/20 at 9:10 A.M. revealed two trash cans located in the nursing home serving kitchen were uncovered and trash was exposed. No lids were available and the trash cans were not in use. Interview on 03/02/20 at 9:14 A.M. with Dietary Staff #518 confirmed the trash lids were not used to cover trash cans. Interview on 03/02/20 at 11:15 A.M. with Dietary Manager #510 stated the lids have never been utilized to cover the trash can. Observation on 03/03/20 at 9:22 A.M. of the trash cans remained uncovered with no lids in the nursing home serving kitchen. The trash cans were not in use. Observation on 03/03/20 at 9:29 A.M. of the main kitchen found one trash can was not in use and remained uncovered with no lid. Review of the facility's policy titled, Fulton Manor/Fulton Suites Food and Nutrition Services, last revised September 2017, revealed all garbage and refuse is disposed of according to the health department regulations.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview and review of the facility's policy, the facility failed to ensure the residents were protected against infection with the appropriate use of personal protective equipment (PPE) and hand hygiene. This affected four residents (#9, #26, #32 and #52) of 19 residents who received a hall tray. This had the potential to affect all 64 residents residing in the facility. Findings include: 1. Review of the medical record for Resident #52 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment, dated 11/14/19, revealed the resident's cognition was intact and had no behaviors. Review of Influenza A & B laboratory result, dated 02/23/20, revealed the active flu A was detected. Review of the physician's orders [REDACTED].M. of Resident #52 revealed she was in her room on droplet precautions and was actively coughing. The resident's room had a sign indicating to enter the room, you need a mask and gloves, which were outside the room. Resident #52 had her call light on. State tested Nursing Assistant (STNA) #440 went into the room without a mask or gloves. Resident #52 asked for new ice and no water in her personal big gulp cup. STNA #440 took the big gulp cup and stated she would return. The STNA returned with ice in the big gulp cup. During this observation, the STNA was observed to not wash her hands when she entered or left the resident's room. Interview on 03/02/20 at 1:46 P.M. with STNA #440 confirmed she had not washed her hands before and after care and did not put gloves and a mask one. The STNA verified she put ice in the same cup as she took from the resident's room and the cup was not sanitized. The STNA #440 revealed she was an agency STNA and she didn't know what they were doing to pass ice water while on droplet precautions. The STNA then confirmed she did not see the sign on the door. 2. Observation on 03/02/20 at 12:02 P.M. during the lunch trays being passed on the 400-hall revealed Dietary Aide (DA) #516 was observed putting on personal protective equipment (PPE) and did not wash or sanitize hands prior. DA #516 applied a mask and then gloves. The DA touched her face with the gloves as she positioned the mask. She then served a tray to Resident #32 in her room and assisted the resident (on droplet precautions) with organizing the items on her bedside table and setting up food tray. Observation of a sign posted on the door of Resident #32 stated to wear a mask and gloves when entering and the supplies were outside of the room. The DA #516 did not do hand hygiene after removing the PPE or assisting with the next tray. The DA #516 came out of the room with the PPE and removed the PPE as she walked down the hall. The DA #516 threw the PPE in the trash can in a room titled Nourishment. She then went to the cart and picked up a tray and delivered it to Resident #9 in the resident's room. She touched Resident #9's clothing, blanket, and bedside table then assisted with food set up. The DA did not do hand hygiene before or after assisting the resident in the room. The DA then proceeded to assist Resident #26 in her room (on droplet precautions) by getting the food tray off the cart, then putting the tray back on the cart to apply PPE. Again, the DA did not do hand hygiene before or after assisting Resident #26. The DA once again walked down to the room titled Nourishment to dispose of the PPE. The DA then applied PPE and took the last tray off the food cart and delivered to Resident #52 in her room (on droplet precautions). The DA came out of the room into the hallway with PPE on and was questioned about her knowledge of infection control, hand hygiene and PPE. Interview on 03/02/20 at 12:19 P.M. with DA #516 confirmed she did not use hand hygiene in between residents, before and after applying PPE. The DA #516 revealed she did not know the order PPE was applied and stated it was her first day passing trays to resident rooms. Interview on 03/02/20 at 12:22 P.M. with Dietary Manager (DM) #517 revealed the DA #516 was on her first day of training passing trays. The DM revealed DA #516 had not had infection control training prior to working 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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) floor. The DM revealed they were short staffed, and DA #516 was pulled from orientation to help with food service. The DM was asked for clarification two times revealing no orientation with infection control was done for the DA #516 previously. Interview on 03/02/20 at 12:40 P.M. with the Administrator revealed she had no knowledge of DA #516 serving food prior to infection control training. Interview on 03/02/20 at 1:10 P.M. with Food Service Director (FSD) #510, DM #517 and the Administrator. The FSD stated DA #516 had infection control orientation in a different department and has worked for them since October 2019 passing trays in the dining room and in the hospital. The FSD verified the same infection control practices would be used in all work environments. He provided a signed statement from DA #516 stating she had previously been trained in infection control. The Administrator and FSD #510 revealed DA #516 would be trained again on infection control. Review of the facility's policy titled, Water Pass, dated 12/31/18, revealed for residents on isolation precautions as per the Infection Preventionist, the staff will take a disposable cup into the room, fill the reusable cup and then dispose of the foam cup along with their PPE upon leaving the room. Review of the facility's policy titled, Guidelines for the Control of Healthcare-associated infections, dated 10/11/18, revealed PPE must be readily available near the resident's room, donned upon entering the resident room, removed and hand hygiene performed when leaving the room. Review of the facility's policy titled, Standard Precaution-Personal Protective Equipment, dated 06/14/18, revealed hands must be decontaminated prior to putting on gloves. The policy further revealed hands should be washed or use alcohol-based hand sanitizer after gloves are removed. The policy revealed gloves should not be worn in the hallways.