STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365747	A. BUILDING _____ B. WING _____	09/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASTORIA PLACE OF WATERVILLE	555 ANTHONY WAYNE TRAIL WATERVILLE, OH 43566

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, local health department staff interview, review of census, review of facility COVID-19 testing logs, review of staffing schedules, review of the facility policy, and review of the Centers for Disease Control (CDC) guidelines, the facility failed to follow policy and guidelines to cohort COVID-19 positive residents and assign dedicated staff to provide care only for COVID-19 positive residents. This had the potential to affect 19 residents who were not COVID-19 positive and resided on the C Hall (#03, #06, #10, #11, #12, #17, #23, #25, #32, #33, #40, #41, #44, #49, #60, #65, #72, #74, and #75). The facility census was 68. Findings include: 1. Observation on 09/02/20 at 8:38 A.M. of the C Hall secured behavior unit revealed eight rooms on the hall. All eight rooms had signs indicated the residents were on droplet isolation and personal protective equipment (PPE) was available in carts outside each of the rooms. room [ROOM NUMBER], #207, #208, #210, #212, and #218 were double occupancy rooms. Review of the facility census revealed Resident #44 and Resident #51 both resided in room [ROOM NUMBER]. Review of the COVID-19 Testing Log for Positive Residents and the COVID-19 Testing Log for Presumed Positive Residents revealed both were tested on [DATE] for COVID-19. On 08/22/20 Resident #44 was negative for COVID-19 and Resident #51 was COVID-19 positive. Both residents remained in room [ROOM NUMBER] and both residents were placed on droplet isolation. Resident #44 did not develop any COVID-19 symptoms. Review of the facility census revealed Resident #33 and Resident #18 both resided in room [ROOM NUMBER]. Review of the COVID-19 Testing Log for Positive Residents and the COVID-19 Testing Log for Presumed Positive Residents revealed both were tested on [DATE] for COVID-19. On 08/22/20 Resident #33 was negative for COVID-19 and Resident #18 was COVID-19 positive. Both residents remained in room [ROOM NUMBER] and both residents were placed on droplet isolation. Resident #33 did not develop any COVID-19 symptoms. Review of the facility census revealed Resident #32 and Resident #29 both resided in room [ROOM NUMBER]. Review of the COVID-19 Testing Log for Positive Residents and the COVID-19 Testing Log for Presumed Positive Residents revealed both were tested on [DATE] for COVID-19. On 08/22/20 Resident #32 was negative for COVID-19 and Resident #29 was COVID-19 positive. Both residents remained in room [ROOM NUMBER] and both residents were placed on droplet isolation. Resident #32 did not develop any COVID-19 symptoms. Review of the facility census revealed Resident #65 and Resident #64 both resided in room [ROOM NUMBER]. Review of the COVID-19 Testing Log for Positive Residents and the COVID-19 Testing Log for Presumed Positive Residents revealed both were tested on [DATE] for COVID-19. On 08/22/20 Resident #65 was negative for COVID-19 and Resident #64 was COVID-19 positive. Both residents remained in room [ROOM NUMBER] and both residents were placed on droplet isolation. Resident #65 did not develop any COVID-19 symptoms. Review of the facility census revealed Resident #41 and Resident #8 both resided in room [ROOM NUMBER]. Review of the COVID-19 Testing Log for Positive Residents and the COVID-19 Testing Log for Presumed Positive Residents revealed both were tested on [DATE] for COVID-19. On 08/22/20 Resident #41 was negative for COVID-19 and Resident #8 was COVID-19 positive. Both residents remained in room [ROOM NUMBER] and both residents were placed on droplet isolation. Resident #41 did not develop any COVID-19 symptoms. Review of the facility census revealed Resident #74 and Resident #37 both resided in room [ROOM NUMBER]. Review of the COVID-19 Testing Log for Positive Residents and the COVID-19 Testing Log for Presumed Positive Residents revealed both were tested on [DATE] for COVID-19. On 08/22/20 Resident #74 was negative for COVID-19 and Resident #37 was COVID-19 positive. Both residents remained in room [ROOM NUMBER] and both residents were placed on droplet isolation. Resident #74 did not develop any COVID-19 symptoms. Interview on 09/02/20 at 8:42 A.M. with the Administrator verified COVID-19 positive residents were sharing rooms with residents who tested negative for COVID-19. The Administrator stated it took four days for the test results to return so the roommates of positive residents were presumed positive even though they tested negative because they had four days of continued exposure to the positive roommate. The presumed positive residents remained in the rooms with their positive roommates. The Administrator reported they consulted with the Local Health Department and the Ohio Department of Health and due to the layout of the building and the behavioral needs of the population they serve they decided they would isolate COVID-19 positive residents in place and not move residents to create a COVID-19 positive unit. Interview on 09/03/20 at 8:54 A.M. with Epidemiologist #400 indicated the facility served such a specialized population the focus was on the diligence of staff managing and wearing PPE appropriately as there were concerns regarding moving residents with behaviors off the secured unit to create a COVID-19 unit. Isolating in place was better suited for the facility to decrease the chances of increased spread of infection. Epidemiologist #400 stated the facility should not be cohorting the positive residents with the negative residents. Review of the undated facility Quick Guide titled COVID-19: New Admission and Readmission Observation Area Quick Guide, revealed when there was a positive COVID-19 or high suspicion admission/readmission resident they were to be placed in a private room. The facility could cohort positive COVID-19 persons per CDC guidelines. 2. Additionally, review of the licensed nursing and nursing assistant staffing schedules from 08/30/20 to 09/04/20 revealed there was no dedicated staff assigned to the COVID-19 positive rooms on the secured behavior unit. Interview on 09/02/20 at 7:55 A.M. with State tested Nursing Assistant (STNA) #200 revealed there was no dedicated staff to work with the COVID-19 positive residents. STNA #200 reported STNAs were assigned to a hall and would cover the care needs of all residents on the hall including COVID-19 positive or negative. Interview on 09/02/20 at 8:46 A.M. with STNA #250 reported there was no dedicated staff assigned to work with just the COVID-19 positive residents. STNA #250 verified they were assigned to the hall and provided care to all the residents. Observation on 09/02/20 at 9:00 A.M. revealed STNA #260 applied PPE and entered room [ROOM NUMBER] to provide care to Resident #64, who was positive for COVID-19. Upon completion of Resident #64's care, STNA #260 doffed her PPE and completed hand hygiene prior to exiting the room. A new N95 mask was applied. A call light went on for room [ROOM NUMBER] and STNA #260 entered the room which housed Resident #3 and Resident #10, who were both COVID-19 negative. Observation on 09/02/20 at 10:27 A.M. of the C Hall revealed STNA #270 was going room to room passing snacks and juice to all residents on the hall. STNA #270 asked residents to stand in their doorways and to wear masks in order to receive their requested snacks. STNA #270 verified there was no dedicated staff and the STNAs on the floor provided care for all the residents. Review of the CDC Guidance titled Resident With New-Onset Suspected or Confirmed COVID-19, revealed Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated Health Care Provider (HCP) Staff. Place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing. If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. This is an example of continued non-compliance from the survey completed on 08/12/20.

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.