STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366456	A. BUILDING _____ B. WING _____	**10/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR MEDICAL CENTER INC	**1454 EAST MAPLE STREET NORTH CANTON, OH 44720**

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure staff were adequately trained to identify type of precautions and appropriate use of personal protective equipment, to ensure a lunch meal was served with in an appropriate manner to a resident on contact precautions, and to update and implement COVID-19 policies. This had the potential to affect two residents (Residents #9 and #18) who were on contact precautions, one resident (Resident #18) who was provided the lunch meal on 10/05/20 in incorrect manner, and all residents residing in the facility. The facility census was 20. Findings include: Review of the record revealed Resident #18 was admitted from the hospital on [DATE] with [DIAGNOSES REDACTED]. Review of the record for Resident #9 indicated she was admitted on [DATE] with [DIAGNOSES REDACTED]. 1. On 10/05/20 at 9:55 A.M., an interview with Environmental Services Staff (ESS) #100 revealed for cleaning resident rooms who were new admissions, she would wear a gown, gloves, mask, and goggles if needed. She indicated she was not sure but had a paper with personal protective equipment (PPE) needed for cleaning rooms of newly admitted residents. After finding the sheet on her cleaning cart, ESS #100 reported PPE to be used included gown, mask, goggles or face shield, and gloves. If goggles were not available in the isolation cart outside the resident's room she would ask the nurse for them. On 10/05/20 at 10:06 A.M., an interview with State tested Nursing Assistant (STNA) #105 indicated she had cared for newly admitted residents. PPE included gloves, mask, and a yellow disposable gown. Staff were allowed to wear cloth or surgical masks. In isolation rooms, surgical masks were worn. Staff did not have to wear any eye covering (gogglrs) or a face shield. She thought staff wore eye covering or a face shield in the isolation rooms. STNA #105 checked the isolation cart in front of Resident #18's room. She indicated there was no face shield or goggles available. On 10/05/20 from 12:04 P.M. to 12:18 P.M., an observation outside Resident #18's room was completed. The resident had an isolation cart in the hallway just outside his door and a yellow colored sign attached to the exterior surface of his door instructing to report to nurse before entering the resident's room. Licensed Practical Nurse (LPN) #109 prepared medications then took them into Resident #18's room. She donned a surgical face mask, disposable gown, and gloves prior to entering the resident's room. After she administered medications and provided the resident his meal, an interview was completed at 12:18 P.M. During the interview, LPN #109 was unable state what type of precautions Resident #18 was on. The nurse apologized several times, looked through her report sheets, then checked the electronic medical record. LPN #109 was still unable to state the type of precautions Resident #18 was on. She knew the resident was a new admission. During an interview on 10/05/20 at 5:02 P.M., Acting Director of Nursing (ADON) #112 confirmed both Residents #9 and #18 were on contact precautions due to being new admissions. Residents were maintained on isolation for 14 days following admission or return from a hospital stay. Review of the facility's Transmission Based Precautions (dated 07/01/17) indicated isolation signs with yellow colored backgrounds indicates contact precautions. 2. On 10/05/20 from 12:04 P.M. to 12:18 P.M., an observation outside Resident #18's room was completed. The resident had an isolation cart in the hallway just outside his door and a yellow colored sign attached to the exterior surface of his door instructing to report to nurse before entering the resident's room. LPN #109 was inside Resident #18's room when STNA #105 delivered the resident's meal tray. The STNA placed the meal tray on top of the isolation cart and informed the nurse that the tray was just outside the door. On the plastic meal tray was a palate to keep food warm and a palate cover. Everything else including utensils, cups, and dessert cup were disposable. At 12:12 P.M., LPN #109 took the entire tray into Resident #18's room including the plastic tray, the palate, and palate cover. During an interview on 10/05/20 at 12:38 P.M., the surveyor asked LPN #109 why she took the whole lunch tray into Resident #18's room. The nurse indicated she made a mistake. She agreed there was a disposable Styrofoam plate inside the palate/palate cover. Review of dietary department's COVID-19 Isolation Policy (dated 09/28/20) indicated all residents returning from a hospital stay or a new admission to the facility will be placed in 14 day isolation. All meals will be put on disposable products. 3. Observations on 10/05/20 between 8:24 A.M. and 8:54 A.M. and 9:35 A.M. to 9:55 A.M. revealed no staff were wearing face shields or goggles to provide eye protection. During an interview on 10/05/20 at 9:55 A.M., ESS #100 indicated if she needed a face shield or goggles she would asked the nurse. She approached ADON #112. The ADON indicted face shields and goggles were stored in a room down the hall. The lead charge nurse had a key to the storage room containing PPE. Additional observations on 10/05/20 between 11:38 A.M. and 12:38 P.M., revealed staff were not wearing eye protection. After repeated attempts to obtain additional COVID policies, the facility did not provide a policy regarding eye protection for the staff working directly with residents. During an interview on 10/05/20 at 5:26 P.M., ADON #112 confirmed(NAME)County was color coded orange in the Ohio Public Health Advisor System. Orange indicated an increased exposure and spread of COVID-19. During the exit conference on 10/05/20 at 6:20 P.M., the Administrator indicated staff caring for residents were not wearing eye protection due to the lack of availability of PPE. 4. On 10/05/20 at 6:00 P.M. after sharing with the Administrator that the facility's COVID testing policy was incomplete, he added information to the policy including monitoring of positivity rates and COVID testing for staff based on the county's positivity rates. Review of the COVID-19 Testing Policy (undated) indicated upon suspicion of a COVID-19 infection, the Director of Nursing shall obtain an order to test the individual in question. Residents shall be placed on transmission-based protocols while the test results are pending. The test shall be conducted as soon as is practicable. The test shall be conducted according to the instructions provided by the lab completing the test. Take appropriate action based on results. Included was a chart including testing triggers including symptomatic individual identified, outbreak, and routine testing for staff and residents. The policy included an asterisk on frequency and duration of outbreak testing. Nothing else was provided. The COVID-19 Testing Policy and other COVID-19 policies lacked facility protocols including if a resident refused COVID-19 testing and if a staff refused COVID-19 testing. The policy also lacked the facility's protocol on what to do if they were having difficulties meeting the 48-hour turn-around time for testing.

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.