STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366284	A. BUILDING _____ B. WING _____	06/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMHERST MEADOWS	1610 FIRST STREET NE MASSILLON, OH 44646

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, interview, review of staff in-services, and nursing home guidance from the Centers for Disease Control and Prevention (CDC), the facility failed to ensure staff donned appropriate personal protective equipment, and followed facility policy for storing N95 respirator masks to prevent and/or contain COVID-19. This affected 11 (Resident #4, Resident #8, Resident #14, Resident #20, Resident #25, Resident #27, Resident #28, Resident #34, Resident #40, Resident #48, and Resident #49) of 30 facility residents who resided on the 100 hall. Findings include: On 06/09/20 at 9:10 A.M. an observation of State tested Nursing Assistant (STNA) #1 removing the trash bag from the waste receptacle in the room of a resident, who was on droplet isolation precautions for COVID-19, indicated she was not wearing a N95 respirator mask while performing her job duties. STNA #1 was wearing a yellow gown with a hole in the waist band tied behind her back and a face shield. STNA #1 entered the resident's room and removed the trash bag from the waste receptacle from the room. STNA #1 proceeded to obtain a clean trash bag to place in the waste receptacle. STNA #1 entered the resident's room and shook the clean trash bag to open the bag and then placed the trash bag inside the waste receptacle. An interview with STNA #1 upon exiting the room indicated she was aware she was supposed to wear a N95 mask while performing her job duties. STNA #1 indicated she was provided an N95 mask by the facility and was presently carrying the N95 mask in her pocket. STNA #1 then reached in her pocket and donned the mask. When asked if she had been trained on the appropriate use of the N95 mask and other personal protective equipment she responded she had been in-serviced. STNA #1 then indicated the facility had caused the COVID-19 infections within the facility due to transferring the residents from one unit to another in the facility. STNA #1 stated the COVID-19 infection was not spread by the staff. STNA #1 did not believe the N95 mask protected her from contracting COVID-19 and indicated the mask did not fit her appropriately. STNA #1 demonstrated there was a gap between the mask and her face which left her exposed and at risk for contracting COVID-19. STNA #1 stated the Director of Nursing (DON) was aware of her feelings about wearing the personal protective equipment. STNA #1 stated the facility had provided her with three N95 masks and three separate paper bags to place each used N95 mask at the end of her shift. The N95 mask could be re-used after three days. STNA #1 indicated she felt the practice was disgusting and was not happy about wearing the personal protective equipment in the facility. On 06/09/20 at 9:20 A.M. an interview with the DON indicated all staff were provided an in-service and trained on the proper use of personal protective equipment. The DON indicated STNA #1 was verbally counseled and instructed to wear the personal protective equipment the facility provided while performing her job duties. The DON also indicated STNA #1 was informed the failure to wear the appropriate personal protective equipment would result in termination from the facility. A follow-up interview with the DON on 06/09/20 at 11:30 A.M. indicated STNA #1 was trained on wearing the appropriate personal protective equipment while performing her assigned duties. The DON indicated STNA #1 was assigned to care for the residents who had a positive [DIAGNOSES REDACTED]. Review of CDC Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings revealed Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. To minimize potential cross-contamination, store respirators so that they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly. Clean hands with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary for comfort or to maintain fit). Avoid touching the inside of the respirator. If inadvertent contact is made with the inside of the respirator, discard the respirator and perform hand hygiene as described above. Use a pair of clean (non-sterile) gloves when donning a used N95 respirator and performing a user seal check. Discard gloves after the N95 respirator is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal. A review of the facility policy and procedure titled Progressive Quality Care Policy: COVID 19 [MEDICAL CONDITION] indicated under item (iii) Environmental controls, such as implementation of short-term isolation with staff use of N95 Respirator masks, will be employed in caring for residents suspected or confirmed active COVID-19. The resident will be instructed and assisted to don a regular surgical mask in situations where they are likely to come in contact with other persons, such as during transport. A review of the facility staff in-service provided to the employees on 03/20/20 indicated STNA #1 was provided the training on wearing the N95 respirator mask and other personal protective equipment while caring for residents with the COVID-19 [MEDICAL CONDITION] infection. Review of the facility census revealed Resident #4, Resident #8, Resident #14, Resident #20, Resident #25, Resident #27, Resident #28, Resident #34, Resident #40, Resident #48, and Resident #49 resided on the 100 hall which was a dedicated unit for COVID-19 positive residents.

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.