STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365588	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARCADIA VALLEY SKILLED NURSING AND REHABILITATION	25675 EAST MAIN STREET COOLVILLE, OH 45723

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.** Based on observations, staff interview, and policy review, the facility failed to establish and maintain an infection control program regarding the use of personal protective equipment for staff to prevent the transmission of communicable diseases and infections. This affected 18 of 18 residents residing in isolation rooms (Residents #1, #3, #4, #6, #8, #12, #14, #15, #19, #20, #21, #26, #29, #31, #34, #35, #43, and #46). The facility census was 49. Findings include: Review of facility documentation revealed the facility identified 11 residents (Residents #1, #6, #12, #19, #20, #21, #29, #31, #34, #43, and #46) currently on droplet precautions as they were either new admissions to the facility or had been out of the facility for an appointment. The facility was maintaining the residents on droplet precautions for 14 days to prevent the potential spread of COVID-19 in the facility. At the time of this survey, the facility did not have any residents or staff who had tested positive for COVID 19. Seven of the residents who were on droplet precautions (Residents #1, #6, #19, #29, #31, #43, and #46) had room mates who were not on droplet precautions (Residents #14, #15, #4, #8, #26, #35, and #3). Observations on 08/06/20 at 8:45 A.M. revealed Assistant Director of Nursing (ADON) #60 go into Resident #6 and #15's room to give medication to Resident #15. ADON #60 reached inside the room and got a gown hanging on a hook. She put the gown on and proceeded into the room to administer medications to Resident #15. When she came out of the room, she took off the gown and hung it up on a hook right inside the room. There was a second gown hanging inside the room also. The hooks were not labeled and there was no distinction between the two gowns. (Resident #6 was identified as being on isolation precautions. Resident #15 was not identified as being on isolation precautions). Interview with ADON #60 on 08/06/20 at 8:50 A.M. confirmed she had worn a gown when providing care for Resident #15. She stated any staff who enter the room to provide care puts on one of the two gowns hanging by the door. She stated that the two gowns could be used for either resident in the room. Interview with the Director of Nursing on 08/06/20 at 9:20 A.M. revealed the facility is short on isolation gowns. Therefore, they are hanging plastic type isolation gowns inside each resident room. She confirmed all staff share the same gowns. She stated Resident #6 had been out for a doctor appointment and that is why she was on droplet precautions. She confirmed Resident #15 did not have a reason to be on isolation. She stated two gowns are hung inside the room. One gown is to be used for one resident and the second is to be used for the second resident. She stated the hooks are supposed to be labeled with an A for A bed and a B for B bed. She confirmed the hooks in Resident #6 and #15's room were not labeled in any way to distinguish which gown was to be used for which resident. She stated the facility did not have cloth gowns (able to be laundered) for use as isolation gowns. Interview with the Administrator on 08/06/20 at 9:30 A.M. revealed the gowns are hung inside the room and all staff entering that room wear the same gowns. She confirmed the same gown should not be worn for both residents in the room as one resident could potentially have COVID-19 and the other resident may not. She confirmed the facility policy stated the same gown could be used for more than one resident if the residents were infected with the same infectious disease. She confirmed the facility did not have any other gown policy to address more than one staff wearing the same gown or re-using gowns for residents without the same infectious disease. Review of the facility policy titled Standard Precautions and Transmission Based Precautions dated 03/20 revealed standard precautions for all residents all of the time included the use of gloves, gowns, and eye protection. Review of the undated policy titled Optimizing the Supply of Isolation Gowns-Contingency revealed it stated to shift gown use towards cloth isolation gowns. Reusable gowns are typically made of polyester or polyester-cotton fabrics. Gowns made of these fabrics can be safely laundered according to routine procedures and reused. The undated policy titled Optimizing the Supply of Isolation Gowns-Crisis revealed it stated consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same staff when interacting with more than one resident known to be infected with the same infectious disease when these residents are housed in the same location (i.e., COVID-19 patients residing in an isolation cohort).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE