STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365859	A. BUILDING _____ B. WING _____	06/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MERRIMAN OF AKRON, THE	209 MERRIMAN RD AKRON, OH 44303

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 observations, staff interview, review of the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Memo QSO-20-14-NH (revised 3/13/20), review of the World Health Organization (WHO) hand hygiene brochure, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure hand hygiene was consistently implemented to potentially prevent the spread of COVID-19 infections. This affected four (#2, #3, #7, and #8) of 48 residents residing in the facility. Findings include: Observation on 06/03/20 at 10:18 A.M. of State tested Nurse Aide (STNA) #50 revealed STNA #50 pushing a cart containing clothing on hangars. STNA #50 stopped at resident room [ROOM NUMBER], took clothing from the cart, walked into the resident room, opened the cupboard and hung the clothes inside. STNA #50 closed the cupboard, walked out of the room, did not wash her hands or use hand sanitizer. STNA #50 then pushed the cart to resident room [ROOM NUMBER], took the clothing from the cart into the resident room, opened the cupboard and hung the clothes inside. STNA #50 closed the cupboard, returned to the cart, did not wash her hands or use hand sanitizer, and proceeded to push the cart to the next resident room. Interview on 06/03/20 at 10:24 A.M. with STNA #50 verified she did not wash her hands or use hand sanitizer after placing laundry in the cupboards in resident rooms #7 and #8 and exiting the rooms. She stated she did not use hand sanitizer when she put the laundry away. STNA #50 stated there probably is someplace to get it, but I just don't have it. She also stated I know I am supposed to wash my hands 24/7 but they will get too dry if I wash them that much, and even if I had the hand sanitizer I probably would not use it because I do not want my hands to get all dried out. STNA #50 continued distributing laundry from the cart to resident rooms without using hand sanitizer or washing her hands. Observation on 06/03/20 at 10:35 A.M. of STNA #52 walking down the hall with folded linens in her arms entering bathroom of resident room [ROOM NUMBER]. She left the bathroom without the linens, exited the room, and walked into resident room [ROOM NUMBER]. STNA #52 did not use hand sanitizer or wash her hands before entering resident room [ROOM NUMBER]. Interview on 06/03/20 at 10:36 A.M. of STNA #52 confirmed she did not used hand sanitizer or wash her hands after leaving resident room [ROOM NUMBER]. STNA #52 stated she had hand sanitizer in her pocket but forgot to use it. Interview on 06/03/20 at 1:59 P.M. with the Director of Nursing (DON) revealed STNAs #50 and #52 had resident assignments, and in addition to the assignments they put clothes and linens away that were located on carts the laundry department brought to the unit. Review of CMS policy memo QSO-20-14-NH revised 3/13/20 titled, Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes, revealed facilities were to Increase the availability and accessibility of alcohol-based hand rubs, and to reinforce strong hand-hygiene practices. Review of the Centers for Disease Control and Prevention (CDC) training titled, Hand Hygiene in Nursing Homes, dated 02/25/19 revealed hand hygiene was an element of standard precautions. It was an important Infection Prevention Control (IPC) practice for breaking the chain of infection. Hand hygiene protects both residents and staff. Hand hygiene was a simple and effective method for preventing the spread of pathogens by direct and indirect contact. The hands of staff members may become transiently contaminated with pathogens after touching a resident or surfaces in their environment. Staff members can transfer those pathogens to themselves and they can also transfer those pathogens to other residents or surfaces. Performing hand hygiene removes pathogens and protects both staff and residents. Since staff cannot tell whether their hands have been contaminated with a pathogen, hand hygiene should be consistently performed. Review of the World Health Organization (WHO) Hand Hygiene brochure titled Hand Hygiene: Why, How, and When?, revised August 2009, revealed hands are the main pathways of germ transmission during health care and hand hygiene is therefore the most important measure to avoid the transmission of harmful germs and prevent health care-associated infections. The brochure further revealed hand hygiene is indicated after touching any object or furniture when leaving the patient surroundings to protect the health-care environment against germ spread.

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