STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395780	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAIR ACRES GERIATRIC CENTER	**340 N. MIDDLETOWN ROAD LIMA, PA 19037**

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 review of guidance from the Centers for Disease Control and the Pennsylvania Department of Health, as well as observations and staff interviews, it was determined that the facility failed to ensure that staff performed proper hand hygiene and wore appropriate personal protective equipment when providing care on two of five designated COVID-19 units observed (Building Six - First and Second Floor). Findings include: Guidance from the Centers for Disease Control (CDC - a national health protection agency) regarding the use of Personal Protective Equipment (PPE - protective garments and/or equipment designed to protect the body from infection or injury) for Coronavirus Disease 2019 (COVID-19 - an infectious disease caused by [MEDICAL CONDITION], that can cause fever, cough, fatigue and/or breathing problems), dated May 22, 2020, included that when caring for a person with confirmed or suspected COVID-19, the caretaker was to use an N-95 respirator (a face mask designed to achieve a very close facial fit and very efficient filtration of airborne particles), gloves, an isolation gown and eye protection, and that the preferred PPE for eye protection was a face shield or goggles. The Pennsylvania Department of Health - Health Alert Network (PAHAN) 509, updated May 29, 2020, included that residents with a positive COVID test, who are within the parameters for transmission-based precautions, were to be placed in a Red Zone and that full PPE was to be worn when caring for these residents. Interview with Employee E3 on June 18, 2020, at 9:40 a.m. revealed that the first and second floors of Building Six were designated as COVID-19 units and all residents residing on the two floors had tested positive for COVID-19, and all staff entering the COVID-19 units were required to wear an N-95 mask, an isolation gown and eye protection, and that gloves were required when entering a resident's room. Employee E3 also stated that both units had residents with dementia (progressive [MEDICAL CONDITION] disease of the brain). Observations on the first floor of Building Six on June 18, 2020, at 9:45 a.m. revealed that one resident was walking in the hallway, there were seven residents in the dining room and eight residents in the activity room. At 9:45 a.m. Employee E4 was standing in the hallway, documenting on the wall kiosk, while wearing an isolation gown and a red cloth facemask. Interview with Employee E4 at that time revealed that the facility provided him/her with training regarding what PPE to wear in a COVID unit (an N-95 mask, isolation gown, and eye protection) and provided him/her with an N-95 mask, but he/she had not been using it because he/she had a problem with it (gestured, pointing to his/her nose). Observations on the first floor of Building Six on June 18, 2020, at 10:15 a.m. revealed that Employee E5 was mopping the floor of the dining room. There were seven residents seated in the dining room (appropriately distanced). Employee E5 was wearing a blue cloth facemask and gloves, and was not wearing a gown and eye protection. Interview with Employee E5 at that time revealed that he/she was wearing complete PPE earlier, but had to remove it because it got hot. Employee E5 stated that he/she would put it back on after he/she was done mopping the floor. Observations on the first floor of Building Six on June 18, 2020, at 10:30 a.m. revealed that Employee E6 was standing in front of the activity room while wearing an isolation gown and a black printed cloth mask with an air valve. Interview with Employee E3 on June 18, 2020, at 10:33 p.m. revealed that Employee E6 informed him/her that the mask he/she was wearing was an N-95 mask. Observations on the second floor of Building Six on June 18, 2020, at 10:40 a.m. revealed that two residents were seated in front of the nursing station and one resident was wandering in the hallway approaching staff. Employee E7 approached the surveyor to introduce himself/herself. Employee E7 was wearing an N-95 mask, but was not wearing a gown and eye protection. Interview with Employee E7 on June 18, 2020, at 10:41 a.m. confirmed that staff in the COVID unit were required to wear a gown and eye protection. Observations on the second floor of Building Six on June 18, 2020, at 10:50 a.m. revealed that Employee E8 was seated in the nursing station with a surgical mask on. Employee E8 was not wearing an N-95 mask, a gown and eye protection. Interview with Employee E8 at that time revealed that from his/her understanding, complete PPE (N-95 mask, gown, eye protection and gloves) were to be worn only when inside a resident's room, due to close contact with the resident. The surveyor asked Employee E8 if the resident seated by the nursing station in front of Employee E8 was considered a close contact, and Employee E8 responded, I guess, I should have, I don't know. Observations on the second floor of Building Six on June 18, 2020, at 10:59 a.m. revealed that Employee E9 was in the hallway pushing an activity cart while wearing a black cloth mask. Employee E9 was not wearing a gown and eye protection. Interview with Employee E9 at that time revealed that he/she was wearing complete PPE earlier when he/she entered a resident's room, but he/she took it off upon leaving the room. While interviewing Employee E9, a confused resident who was wandering in the hallway approached both Employee E9 and the surveyor and started talking to Employee E9. The employee stroked the resident's left arm then continued to pat the resident's back with his/her left hand. Without performing hand hygiene, Employee E9 then wiped his/her left face with the same hand he/she used to touch the resident. Interview with Employee E3 on June 18, 2020, at 11:10 a.m. confirmed that the staff should have worn complete and correct PPE when entering the first and second floors of Building Six. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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.