| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366462 | A. BUILDING _____ B. WING _____ | 07/21/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| CANAL WINCHESTER CARE CENTER | 6800 GENDER ROAD CANAL WINCHESTER, OH 43110 |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on the unprecedented coronavirus global pandemic that resulted in the Presidential declaration of a State of National Emergency declared [DATE], Nursing Home guidance from the Centers for Disease Control and Prevention (CDC), local health department guidance, policy review, observation, record review and interview, the facility failed to ensure policies and procedures designed to identify and mitigate infections with [DIAGNOSES REDACTED]-CoV-2 virus had been sufficiently developed in accordance with CDC recommendations and failed to ensure interventions to contain and prevent the spread of COVID-19 infections were consistently implemented. This had the potential to affect all 63 residents residing in the facility at the time of the survey. Findings include: 1. On [DATE] from 12:00 P.M. to 1:30 P.M. a tour of the facility with Operations Manager (OM) #2 and Infection Control Nurse (ICN) #3 revealed the facility 200 unit was designated as a unit that housed residents who had potential exposure to COVID-19. There were four residents residing on the unit (#5, #10, #50 and #54) who were identified to have been possibly exposed to COVID-19 from a State tested Nursing Assistant who had tested positive. In addition, the unit also had additional residents residing on it who were not COVID positive, symptomatic of COVID or who had been exposed to COVID. During the tour and subsequent survey, the following observations and concerns were identified: a. Review of Resident #50's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. The resident's plan of care was updated on [DATE] to include the resident was placed in droplet precautions, monitor for signs and symptoms and COVID-19 testing as ordered. On [DATE] during the tour beginning at 12:00 P.M. the door to Resident #50's room was observed to be closed with a netting type stop sign which was across the door with Velcro. There was no personal protective equipment (PPE) at the entrance to the room. There were two red barrels in the room with a yellow trash bag hanging over the top that was not set up or in use. During the tour, interview with OM #2 revealed Resident #50 was not currently in his room but rather was observed sitting across from his room in the lounge by the nurse's station. The resident was sitting in a chair in the community lounge area and was observed to be wearing a face mask. At the time of the observation and interview, OM #2 revealed Resident #50 should not be out of his room because he was on droplet precautions. At the time of the observation, interview with ICN #3 revealed Resident #50 was on fall watch and staff needed to keep an eye on him. She admitted the resident should remain in his room since he was on droplet precautions. She stated she didn't know why there was no PPE available at the room or why infection control containers were not properly set up in the resident's room. On [DATE] at 4:17 P.M. interview with LPN #6 revealed Resident #50 was on droplet isolation precautions but was also a fall risk with behaviors. Anytime he was left alone, he would fall or get agitated and that was the reason why he was out in the lobby, it was unsafe to leave him in his room. She stated she didn't make the decision herself to allow him out of his room. She stated the resident wears a mask when out in the lounge area and doesn't fool with it and there were usually no other residents around him. She stated this had not been her decision but rather where the resident was when she arrived to work. b. Review of Resident #5's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED].M. observation of Resident #5's room revealed there was no PPE readily available for staff to use upon entering the room. This was confirmed by the OM #2 at the time of the observation. c. Review of Resident #10's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Medication Administration Record [REDACTED]. The resident's care plan was updated on [DATE] to reflect the resident was placed on droplet isolation related to potential exposure to COVID-19. During the tour of the facility, on [DATE] beginning at 12:00 P.M. observation of Resident #10's room revealed there was no PPE readily available for staff to use upon entering the room. This was confirmed by OM #2 at the time of the observation 2. During the tour of the facility on [DATE] beginning at 12:00 P.M. observation of the 100 hall revealed this hall was designated for residents who were under quarantine/observation because they were either newly admitted or readmitted from the hospital. a. Review of Resident #28's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED].#28 had a physician order [REDACTED]. observation of Resident #28's room revealed there was a PPE rack on the door. However, there were no clean gowns available on the rack for use. There were three used disposable gowns hanging on the back of the door (exposed to the hallway) and one surgical mask hanging on a hook. This was confirmed by OM #2 at the time of the observation. b. Review of Resident #57's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. On [DATE] during a tour of the facility beginning at 12:00 P.M. observation of Resident #57's room revealed there were used disposable gowns hanging on the back of the door which were exposed to the hall. This was confirmed by OM #2 at the time of the observation. c. Review of Resident #53's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. On [DATE] beginning at 12:00 P.M. a tour of the facility revealed Resident #53's room had used gowns hanging on the back of the door which were exposed to the hall. This was confirmed by OM #2 at the time of the observation. d. Review of Resident #11's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. On [DATE] beginning at 12:00 P.M. a tour of the facility revealed Resident #11 had no PPE readily available for staff use at the entrance to the room. This was confirmed by OM #2 at the time of the observation. e. Review of Resident #17's medical record revealed an admission date of [DATE] and readmission date of [DATE] with [DIAGNOSES REDACTED]. Record review revealed Resident #17's current plan of care indicated the resident was on droplet precautions for preventative measures (related to COVID-19) On [DATE] beginning at 12:00 P.M. a tour of the facility revealed Resident #17 had PPE available at the door to the room. There were used disposable gowns hanging on the back of the door which were exposed to the hall. There were two cardboard boxes in the room at the entrance. The linen box was filled, with no liner in the box. At the time of the observation, State tested Nursing Assistant (STNA) #4 was observed standing inside the room and confirmed there was no liner in the box. ICN #3 who was also present during the tour and STNA #4 proceeded to empty the linen box which was completely full into two bags by picking up the linen and transferring it to the bag, held by ICN #3 who was standing in the doorway. ICN #3 did not first apply a gown (PPE) when she assisted the STNA #4 to empty the linen box. STNA #4 who was in the room was observed to not be wearing a N95 mask and was not wearing any goggles or face shield. When asked why she was not wearing the face shield which were available in the PPE storage unit, she stated she had her glasses on, so she was just using that as her PPE. On [DATE] at 12:30 P.M. while the above observations were occurring with ICN # 3 and STNA #4, Licensed Practical Nurse (LPN) #5 was observed exiting Resident #11's room. LPN #5 came out of Resident #11's room, removed his gown and placed it in the trash barrel just inside the room and then immediately left the area. LPN #5 was observed to walk four steps up the hall and then stopped and was asked if he had performed hand hygiene (as this had not been observed). The LPN was observed to still have his face shield and a surgical mask (not N95) on at that time. He was asked if he had changed his surgical mask after exiting the room and he said he had not. The LPN then removed the mask/face shield and without completing any type of hand hygiene grabbed another surgical mask from PPE supplies located in the next resident's room area and placed it on his face. ICN #3 and OM #2 who were present during the observation stated the LPN should go wash his hands with soap and water in the utility room down the hall. No staff who |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366462 | A. BUILDING _____ B. WING _____ | 07/21/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| CANAL WINCHESTER CARE CENTER | 6800 GENDER ROAD CANAL WINCHESTER, OH 43110 |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 1)<br>were working on the 100 hall were observed to be wearing an N95 mask even though there were residents in droplet precautions for COVID-19. OM #2 confirmed the above observations. On [DATE] at 10:53 A.M. interview with ICN #3 revealed staff were expected to wear PPE including gown, gloves and face shield which was already connected to a surgical mask unless there was a confirmed COVID-19 positive resident or a resident displaying signs and symptoms of COVID-19. In this situation, staff would be expected to wear a N95 mask and goggles. 3. On [DATE] at 1:06 P.M. Housekeeping Supervisor #7 was observed applying PPE. The supervisor washed her hands, applied a gown, took off a worn surgical mask and then placed the mask in her pant pocket. The supervisor did not perform hand hygiene after removing the worn mask. She was asked at the time of the observation why she placed her worn mask in her pant pocket to which she replied so she could reuse it. ICN #3 who was present at the time of the observation/interview, informed Housekeeping Supervisor #7 she should not place the used mask in her pant pocket but rather dispose of it. ICN #3 also verified the supervisor had not performed any type of hand hygiene related to the removal of a used mask. 4. The following follow up interviews and information was obtained related to the above concerns: On [DATE] at 1:06 P.M. during an interview with ICN #3, the ICN was asked why PPE was not readily available for the residents noted above. ICN #3 revealed she did not know. She stated it had been there yesterday even though the rooms did not have a cart or hanging tote available at the time the observations were made on this date She also again confirmed the above rooms that had used PPE gowns hanging on the back of the doors and the used surgical mask. ICN #3 revealed it appeared staff were reusing this PPE even though they had not advised staff to reuse PPE. ICN #3 revealed reusing PPE was not the facility policy. ICN #3 revealed it was the responsibility of the STNAs to stock PPE. During the interview, ICN #3 verified STNA #4 should have been wearing a face shield even if she wore glasses. She stated N95 masks were not required to be used unless residents had symptoms of COVID-19 or they had tested positive. ICN #3 revealed the PPE required for a resident on droplet precautions was a gown, gloves and regular mask. She stated all new admissions had been tested with one negative test prior to admission. She also stated they had a nursing assistant who tested positive and they had identified four residents, Resident #5, #10, #50 and #54 who had exposure to this nursing assistant so these four residents were placed in droplet isolation to be observed for potential signs and symptoms of COVID-19. ICN #3 was asked to provide the directive/guidance used to determine staff did not need to wear an N95 masks and face shields/goggles for residents suspected to have COVID-19 (who were in droplet precaution isolation). This information was never provided. On [DATE] at 3:50 P.M. during an interview with ICN #3, the ICN was asked why there were disposable gowns hanging on the backs of the doors to resident rooms. She stated originally, the facility was going to try to conserve gowns and they used to have a luggage cart that they put them on and kept them hanging on the luggage cart which was kept covered with a bag over it. However, they got away from this practice when therapy staff got confused about it and now all staff were to obtain a new gown to be used each time they entered a room of a resident in droplet isolation. ICN #3 revealed the facility had previously used the 500 unit as the COVID unit but then moved residents who might have been placed on this unit to the 100 and 200 hall units. ICN #3 then indicated the gowns were meant to be disposable and were not to be re-used. On [DATE] at 10:00 A.M. interview with the Director of Nursing regarding the reuse of PPE gowns revealed facility staff were reusing gowns. She stated every staff gets one gown per resident in isolation/per shift. They get their own gown and face shield with mask. Staff get a regular surgical mask when entering the building to be worn with residents who were not in isolation. If a resident was in isolation, they can't wear just a regular/surgical mask so they either take off their surgical mask and put on a surgical mask with face shield attached or wear the surgical mask with face shield over their surgical mask. The DON revealed gowns were reused throughout the day but only by that employee for that one resident. They hang the gowns on the back of the resident's door. She stated this guidance was given to her by the local health department as a way to conserve PPE. She was asked why ICN #3 had such a different answer regarding re-using PPE to which she replied she wasn't sure what the confusion was. The DON was asked if the facility had a policy/procedure on how reusing the disposable gowns and/or masks was to be accomplished, i.e. stored, removed, marked by staff with names, etc. The DON revealed she would check. No additional information was provided. On [DATE] at 12:05 P.M. interview with the local health department Infection Control Nurse (ICN) #104 revealed staff should be wearing N95 masks if available for any resident who was in isolation on droplet precautions. ICN #104 revealed if there was not a shortage of PPE, the best practice was to change PPE gowns on each occasion (each time entering the resident's room). She stated it was also best to have residents who were in isolation related to COVID-19 residing in a section of a wing or a separate wing and not spread throughout the units intermingled with other residents. ICN #104 revealed she thought she had discussed this with the facility in the past and had been talking to the DON on a regular basis. She stated she would also send recommendations/guidance to the facility via email. On [DATE] at 11:31 A.M. an email from OM #2 revealed the facility was not using dedicated staff to care for the residents on droplet isolation for COVID-19 who were residing on the 100 and 200 hall units. She stated they try and be consistent with staffing assignments but there would be instances where staff would work alternate halls. OM #2 continued by again stating the facility did not have dedicated staff for the residents with possible suspected cases who were residing on the 100 and 200 hall units and verified there were presently both residents who have been exposed to COVID-19 from a staff member who resided on the 200 unit hall with residents who had not been exposed on the same unit. She also verified the 100 hall unit had both new admissions who were quarantine with droplet isolation precautions on the unit as well as residents who were not on isolation precautions. She stated the same staff were caring for all the residents on both units. Review of the facility Transmission Based Precautions: Droplet Precautions policy, dated [DATE] and reviewed [DATE] revealed to limit the movement and transport of the patient/resident from their room for essential purposes only. Review of e-mail guidance from the(NAME)County Local Health Department infectious disease nurse, RN/BSN, revealed all recommended PPE should be worn during care of residents under observation; this includes use of an N95 mask or higher-level respirator (or face mask if a respirator is not available, eye protection (i.e., goggles or a disposable face shield that covers the front and side of the face:, gloves and gown. An additional email from the(NAME)County Local Health Department revealed for COVID-19 the correct PPE to use when someone was in droplet/contact precautions would be an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Testing could be considered to increase certainty the resident was not infected. As far as quarantining residents from the hospital, a single negative test upon admission/re-admission does not mean the resident was not exposed or would not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Residents could be removed from quarantine/observation if they remained afebrile and without symptoms of COVID-19 for 14 days after their last exposure. Testing at the end of this period could be considered to increase certainty. Review of the Centers for Disease Control and Prevention (CDC) guidance updated [DATE] revealed recommended infection prevention and control practices when caring for a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection as a measure to limit healthcare personnel exposure and conserve PPE included to consider designating entire units within the facility, determine how staffing needs would be met as the number of patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection increases and if healthcare personnel become ill and were excluded from work. Limit transport and movement of the patient outside of the room to medically essential purposes. In regards to PPE, healthcare personnel who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher level respirator, gown, gloves and eye protection. Personal protective equipment training, on understanding and demonstrate when to use PPE, what PPE was necessary, how to properly apply (don), use and remove (doff) PPE in a manner to prevent self-contamination, how to properly dispose or disinfect and maintain PPE and the limitations of PPE. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. Put on an N95 respirator or equivalent or higher-levels respirator before entry into the patient room or care area. Disposable respirators and facemask should be removed and discarded after exiting the patient room or care area and closing the door unless implementing extended use or reuse. Perform hand hygiene after removing the respirator or face masks. Eye protection: put on eye protection (i.e. goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area. Protective eyewear (e.g. safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays. Gowns, put on a clean isolation gown upon entry into the patient room or area, change the gown if it becomes soiled, remove and discard the gown in a dedicated container for waist or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use. Review of the policy and procedure titled, Strategies for Optimizing Personal Protective Equipment: Facemasks, Gowns, N95 Respirators and Eye Protection dated [DATE] revealed: Strategies for Optimizing the Supply of Isolation Gowns which |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **366462** | A. BUILDING _____ B. WING _____ | **07/21/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **CANAL WINCHESTER CARE CENTER** | **6800 GENDER ROAD CANAL WINCHESTER, OH 43110** |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 2)<br>included Contingency capacity: Shift gown use towards cloth isolation gowns. Reusable (i.e., washable) 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. Use of expired gowns beyond the manufacturer-designated shelf life for training Consider use of coveralls Use gowns or coveralls conforming to international standards Crisis capacity Extended use of isolation gowns Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same health care personnel (HCP) when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious [DIAGNOSES REDACTED]. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices. Re-use of cloth isolation gowns Prioritize gowns During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures. During high contact patient care activities like dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care. When no gowns are available. Consider using gown alternatives that have not been evaluated as effective like disposable lab coats, reusable patient gowns, reusable lab coats, disposable aprons Strategies for Optimizing the Supply of Facemasks Contingency capacity Extended use of facemasks for multiple encounters with different patients, without removing it between encounters Must remove and discard facemasks if soiled, damaged, or hard to breathe through Restrict facemasks to use by HCP, rather than patients for source control Have patients with symptoms of respiratory infection use tissues or other barriers to cover their mouth and nose. Crisis capacity Use facemasks beyond the manufacturer-designated shelf life during patient care activities Implement limited re-use of facemasks where in HCP uses same facemask for multiple encounters with different patients but removing it after each encounter The facemask should be removed and discarded if soiled, damaged, or hard to breathe through Not all facemask can be re-used (facemask with elastic ear hooks may be more suitable) When no facemasks are available Use a face shield that covers the entire front (that extends to the chin or below) and sides of the face with no facemask Consider use of ventilated headboards HCP use of homemade masks (not considered PPE, capability to protect is unknown, use caution) |