STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365880	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF COSHOCTON	**100 SOUTH WHITEWOMAN STREET COSHOCTON, OH 43812**

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 -** Many	**Provide and implement an infection prevention and control program.** Based on observation, interview and policy review the facility failed to implement effective infection control practices related to the use and storage of personal protective equipment (PPE) to prevent the spread of COVID-19. This had the potential to affect all 35 residents residing in the facility. Findings include: 1. On 09/09/20 at 8:23 A.M. observation with the Director of Nursing (DON) revealed State tested Nursing Assistant (STNA) #31 was observed to Resident #2's room. Resident #2 was identified to reside in an isolation room on the facility quarantine unit related to COVID-19 The STNA entered and then shut the resident's door without first applying an N95 mask. The Director of Nursing (DON) confirmed the observation and indicated STNA #31 should have worn an N95 into Resident #2's room. Review of the facility undated PPE guidance revealed when entering an isolation room, the following were required: N95 mask, face shield or goggles, gown and gowns. 2. On 09/09/20 at 9:12 A.M. Registered Nurse (RN) #1 was observed standing outside Resident #5's room wearing an N95 mask and a face shield. Resident #5 was identified to reside in an isolation room on the facility quarantine unit related to COVID-19. The room was a semi-private room with two beds in it, however only Resident #5 was residing in the room at the time of the observation. RN #1 was observed to remove her face shield and N95 mask and folded and placed the N95 mask in her pant pocket. RN #1 then reached into Resident #5's room and obtained a used gown and N95 mask that was observed laying on the unoccupied bed in the room. The RN proceeded to provide assistance to the resident. Before leaving the room, she removed her used N95 mask and gown and placed them both on the unoccupied bed in the room. Interview with RN #1 at the time of the observation revealed she leaves the N95 mask and gown on the bed and reuses them during her shift since there was only one resident in the room. On 09/09/20 at 10:25 A.M. observation with the DON verified the N95 mask and gown laying on the bed inside Resident #5's room. The mask was open to air on the bed and not placed in any type of bag. The DON reported the resident was ambulatory in the room with a wheelchair and could possibly touch the mask. There was no evidence of paper bags (for PPE storage) on the unit. The DON revealed staff should be utilizing brown bags to store their N95 mask but were not based on this observation. Review of the facility COVID-19 policy, dated 03/04/20 and revised 08/31/20 revealed the facility would provide employees with a brown paper bag at the beginning of every shift and the employee would write their name on the bag with a marker. The employee would utilize the paper bag to store their mask when not in use during their shift. If an employee goes on break, uses the restroom, leaves patient care areas, etc., the mask would be removed and placed in the marked brown paper bag. This deficiency substantiates Complaint Number OH 389.

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