STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365972	A. BUILDING _____ B. WING _____	**10/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANFIELD HEALTHCARE CENTER	**2958 CANFIELD RD YOUNGSTOWN, OH 44511**

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 maintain adequate infection control practices, including the proper use of handwashing/hand sanitation during meal delivery to prevent the spread of COVID 19 or other potentially infectious disease. This affected three residents (#4, #40 and #14) and had the potential to affect all 71 residents residing in the facility. Findings include: On 10/06/20 beginning at 11:40 A.M. the lunch meal was observed with the meal cart being delivered to Unit 2. Staff were observed to begin to deliver and prepare meal trays for the residents eating in their rooms. On 10/06/20 from 11:52 A.M. to 12:00 P.M., State tested Nursing Assistant (STNA) #100 was observed to enter Resident #4's room with a meal tray. While setting up the meal, the STNA repositioned her N-95 mask and then went back to opening lids and containers on the resident's meal tray. The STNA then moved the resident's over bed table with the meal tray to the other side of the bed to make it easier for Resident #4 to reach. STNA #100 left the resident's room, removed a meal tray from the meal cart, and took it into Resident #40's room. The STNA raised the head of Resident #40's bed using the electronic bed control then prepared the meal by opening all food items. Once completed the STNA left the room. STNA #100 then attempted to deliver two additional resident trays, for Resident #12 and #19. However, one of these residents was not in his room and the other had already eaten. After returning both meal trays to the cart, STNA #100 pulled up on the waist of her pants and retied her shoe laces. She then obtained and took a meal tray from the cart into Resident #14's room. She set up and prepared the meal, tearing off the foam lid from the Styrofoam plate, removing lids from the Styrofoam cups, and tearing off the lid from the pudding cup. STNA #100 then exited the room. During the observation of STNA #100 delivering the above meal trays, the STNA failed to wash her hands or use any type of hand sanitizer even after touching her mask, pants and shoes, after touching resident care equipment or between residents. On 10/06/20 at 12:00 P.M., during an interview with STNA #100, the STNA verified she never washed or cleansed her hands between residents or after touching her mask, pants or shoes. The STNA was unable to explain why she did not perform hand hygiene. On 10/06/20 at 3:36 P.M. during an interview with the Director of Nursing (DON), the DON revealed the facility had a recent outbreak of COVID 19 and was continuing testing per outbreak protocol. Review of the facility Standard Precautions Policy, revised 04/01/17 revealed hand hygiene should be performed including before feeding or assisting in dining room or tray pass, after contact with inanimate objects including medical equipment, and for care between residents.

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