STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365585	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDGEWOOD MANOR OF LUCASVILLE I	**10098 BIG BEAR CREEK RD LUCASVILLE, OH 45648**

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 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	Based on record reviews, staff interview, and review of the facility's policy, the facility failed to inform all residents, family, or their representatives by 5:00 PM the next calendar day following the occurrence of a confirmed positive COVID-19 infection. This deficient practice had the potential to affect all 76 residents who resided in the facility, their families and representatives when one resident (R) 2 tested positive for COVID-19. Findings include: Review of R2's COVID-19 Test Results located in the resident's paper medical record indicated that R2 tested positive for the COVID-19 infection on 09/14/20. The Nursing Notes dated 09/14/20, indicated the resident's family and physician had been notified of the infection. There was no evidence that the facility had informed each resident, family or representatives of a confirmed COVID-19 infection by 5:00 PM on 09/15/20. Interview with the Social Service Assistant on 09/17/20 at 12:22 PM, confirmed the facility failed to notify all residents, families, or representatives when R2 tested positive on 09/14/20 for COVID-19. Review of the facility's policy titled, COVID-19 Policy and Procedures, dated 05/01/20 indicated, The responsible parties of all residents will be notified of initial cases and any follow up cases of COVID-19 cases within 24 hours of the confirmation.

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.