STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366060	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBORS AT SYLVANIA	7120 PORT SYLVANIA DRIVE TOLEDO, OH 43617

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** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interview, review of facility COVID-19 Outbreak Line Listing, review of facility policy, review of the facility census, and review of the Centers for Disease Control (CDC) and Prevention guidelines, the facility failed to implement interventions to mitigate the transmission of COVID-19 by separating a symptomatic resident from a non-symptomatic resident at the first sign of illness. This affected one (#100) of three residents reviewed for infection control. The facility census was 64. Findings include: Review of the medical record for Resident #200 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. The resident was transferred to the hospital on [DATE]. Review of the nurse progress notes for Resident #200, dated 08/15/20 at approximately 11:00 A.M., revealed the resident was found to have a fever of 103 degrees Fahrenheit (F). The nurse rechecked the temperature, which was found to be 102.1 degrees F. The resident was rechecked a third time and found to be 98.6 degrees F. At approximately 2:10 P.M. Resident #200 had a fever of 102.6 degrees F and an oxygen saturation level (SPO2) of 93%. The resident was given Tylenol to lower the temperature. The resident's temperature was rechecked at 3:12 P.M. and was 99.4 degrees F. Review of the nurse progress note dated 08/16/20 at 3:40 P.M., revealed Resident #200 had a fever of 102.6 degrees F and SPO2 of 84% at 9:04 A.M. The resident was placed on 2 liters (L) of oxygen, given rectal Tylenol, and orders were placed for a chest x-ray and laboratory work. A recheck of the resident's vitals following the interventions showed the resident had a temperature of 100.0 degrees F and a SPO2 of 90% with 2L of oxygen. After notifying the family of the resident's condition, the family of Resident #200 showed up at the facility and demanded the resident be taken to the hospital. Per the family's request, 911 was called and Resident #200 was taken to the emergency room where she was admitted . Review of the facility COVID-19 Outbreak Line Listing revealed on 08/14/20 Resident #200 had a COVID-19 test performed as a facility wide testing of residents. On 08/15/20, Resident #200 was identified with onset of COVID-19 illness with symptoms of fever and shortness of breath. On 08/17/20 Resident #200 tested positive for COVID-19. Interview on 08/19/20 at 10:45 A.M., the Administrator stated the facility was notified Resident #200 tested positive for COVID-19 while in the hospital on [DATE]. Review of the medical record for Resident #100 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the current quarterly Minimum Data Set (MDS) 3.0 assessment revealed the resident had intact cognition. Review of the nurse progress notes for Resident #100, dated 08/16/20 at 10:50 A.M., revealed a manager on duty spoke to Resident #100 who was concerned about the status of her roommate (Resident #200). Resident #100 stated her roommate had a fever and was insistent the roommate be moved out of her room. Manager on duty attempted to assure Resident #100 the nurses were taking care of the roommate's needs. Resident #100 continued to state the roommate be moved or she will call the Ombudsman and local news channel. A room change was offered for Resident #100, but she declined stating they just need to get her out of here. The manager on duty informed the resident her concerns would be passed on to the nurse on duty. Review of the facility COVID-19 Outbreak Line Listing revealed on 08/14/20 Resident #100 had a COVID-19 test performed as a facility wide testing of residents with results pending. The document identified on 08/19/20 Resident #100 was exhibiting symptoms of temperature of 100.1 degrees F, cough, and shortness of breath. A note indicated the resident had symptoms and was requesting another swab for COVID-19 be done. The test will be completed on 08/19/20. Interview on 08/19/20 at 11:05 A.M. with Resident #100 revealed on the morning of 08/15/20 her roommate, Resident #200, began having fevers and a cough. Resident #100 stated at that time she expressed to Licensed Practical Nurse (LPN) #35 she was worried the symptoms her roommate displayed could be symptoms of COVID-19 and wanted to be moved to a different room. Resident #100 stated she was told they could not move her and was not given a reason. Resident #100 stated the staff began to wear personal protective equipment (PPE) at the time her roommate began developing fevers, but indicated they would wear the same PPE equipment when caring for both her and her roommate. Resident #100 stated her roommate remained in the room with her until her discharge to the hospital on the afternoon of 08/16/20. Resident #100 stated on 08/18/20 she developed symptoms of shortness of breath, body aches, and a cough. The staff swabbed her this morning for COVID-19 and started her on [MEDICATION NAME] (a steroid) and a Z pack (antibiotic). Interview on 08/19/20 at 11:32 A.M., LPN #30 verified Resident #100 was running a temperature of 100.1 degrees F, had complaints of a sore throat, and complaints of feeling achy. LPN #30 verified Resident #100 was tested that morning for concern of COVID-19. Interview on 08/19/20 at 11:33 A.M. with LPN #35 revealed she was the nurse caring for Resident #100 and Resident #200 on the afternoon of 08/15/20. LPN #35 stated Resident #200 began having fevers so both and both her and her roommate, Resident #100, were placed in transmission-based precautions per the facility protocol. LPN #35 stated Resident #100 did express to her she wanted her roommate to be moved out, but they did not have anywhere to put her. LPN #35 also stated she felt both residents at that time were considered exposed and could be permitted to stay in the same room. Interview on 08/19/20 at 12:12 P.M. with the Administrator and Regional Coordinator (RC) verified the facility's policy was to move potentially exposed residents into the quarantine unit if a roommate was suspected to have COVID-19. The Administrator verified she spoke to Resident #100 on 08/16/20 about the room situation but failed to act in moving Resident #100 into the quarantine unit or Resident #200 into isolation. The Administrator stated this could have been because the facility did not have a spare room to move either resident but was unable to provide any additional evidence to support this statement. Review of the facility census for 08/15/20 and 08/16/20 revealed the facility census was 65 both days. The facility capacity was 77. According to the census sheet, Resident #200 and Resident #100 were together in room [ROOM NUMBER]. room [ROOM NUMBER] and room [ROOM NUMBER] were noted to be unoccupied on the census sheet at that time. Review of the undated facility policy titled COVID-19 revealed a flowchart the facility was to follow when identifying potential infections of COVID-19. The chart revealed upon discovering a symptomatic resident, the asymptomatic roommate was to be placed in isolation on the observation unit. Review of CDC guidance at www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html titled Preparing for COVID-19 in Nursing Homes, dated 06/25/20, revealed residents with known or suspected COVID-19 should be placed in a single room if possible pending results of the COVID testing. This deficiency substantiates Complaint Number OH 5044.

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.