STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365507	A. BUILDING _____ B. WING _____	03/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKLD DEFIANCE ILLUMINATE HC DEFIANCE	395 HARDING STREET DEFIANCE, OH 43512

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and policy review, the facility failed to ensure the Advanced Directives were identified in the physician order for [REDACTED]. Findings include: Review of the medical record for Resident #18 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/03/2020, revealed Resident #18 had moderate cognitive impairment. Review of the care plan dated 08/12/19 revealed Resident #18 had a desire to remain a Do Not Resuscitate Comfort Care (DNRCC)-arrest. Review of the current physician orders revealed there was no Advance Directive order for Resident #18. Interview on 03/11/20 at 12:06 P.M. with Registered Nurse (RN) #240 verified there were no Advanced Directive orders in the physician orders. Review of the facility policy titled Advance Directives, dated 07/11/18, revealed an Advance Directive will be added to Physician Order Sheet.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview and policy review, the facility failed to maintain resident privacy during the administration of injections for two (#12 and #56) of two residents observed for administration of [MED]. Additionally the facility failed to provide privacy during the dressing change for one (#56) of one resident observed for dressing changes. The facility census was 59. Findings include: 1. Review of the medical record for Resident #56 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the five day Minimum Data Set (MDS) assessment, dated 02/25/2020, revealed Resident #56 was cognitively intact. Observation on 03/09/2020 at 4:26 P.M. revealed Registered Nurse (RN) #262 went into Resident #56's room and administered an [MED] injection without closing the door or pulling the curtain for privacy. Interview on 03/09/20 at 4:28 P.M., RN #262 verified he administered Resident #56's [MED] into his abdomen, without providing privacy. Observation on 03/11/2020 at 1:30 P.M. revealed a dressing change was being performed on Resident #56's buttocks by Licensed Practical Nurse (LPN) #204 and RN #206. LPN #204 and RN #206 had closed the door, but did not pull the curtain in the room. Resident #56 was the only resident in the room. During the dressing change, the door was abruptly opened and then closed by Housekeeper #300, without the staff identifying themselves or knocking on the door. Resident #56 was rolled on his side with his buttocks uncovered, facing the door at the time the door was opened. Interview at the time of the observation on 03/11/20 at 1:30 P.M., Housekeeper #300 verified she had opened the door to Resident #56's room without identifying herself or knocking. Review of the facility policy titled Resident Privacy and Confidentiality, dated 07/11/18, revealed it is the policy of the facility to ensure that each resident has the right to privacy. For purposes of this policy, the term personal privacy includes accommodations, medical treatment, and personal care. 2. Review of the medical record for Resident #12 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 12/22/19, revealed Resident #12 had moderate cognitive impairment. Observation on 03/09/2020 at 4:20 P.M. revealed RN #262 administered [MED] to Resident #12 in his abdomen and did close the door or pull the curtain to provide privacy. Interview on 03/09/2020 at 4:40 P.M., RN #262 verified he did not close the door or pull the curtain while administering [MED] to Resident #12.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility policy, and staff and resident interview, the facility failed to provide written documentation to the residents and resident responsible parties of a resident transfer to the hospital for four (#12, #18, #54, and #109) of seven residents reviewed for hospitalization s. The facility identified 11 resident discharges to the hospital in the last 30 days. The facility census was 59. Findings include: 1 Review of the medical record for Resident #12 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set (MDS) 3.0 assessment, dated 12/22/19, revealed the resident had no cognitive deficits. Review of progress notes dated 01/09/20 revealed Resident #12 was transferred to the hospital for shortness of breath. Review of progress notes dated 02/08/20 revealed the resident was transferred to the hospital on [DATE] for pneumonia. Further review of progress notes revealed the resident returned to the facility on [DATE]. Review of a Notice of Transfer form dated 01/10/20 and 02/07/20 revealed there were no signatures on the line provided for the resident to acknowledge receipt of the notices. Review of a Notice of Transfer log kept by the social service department revealed no documentation Resident #12 received the notice of transfer upon transfer to the hospital or as soon as practicable for 01/10/20 or 02/07/20. Interview with Resident #12 on 03/10/20 at 9:30 A.M. revealed he was unaware of ever receiving any written information regarding why he was transferred to the hospital. Interview with the Administrator on 03/12/20 at 10:00 A.M. verified there was no documentation Resident #12 or the responsible party had received a copy of the notice of transfer forms when the resident had been transferred to the hospital. 2. Review of the medical record for Resident #109 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. [DIAGNOSES REDACTED]. Review of a five day MDS assessment, dated 02/28/20, revealed Resident #109 had short and long term memory deficits and modified independence with cognitive skills for daily decision making. Review of progress notes dated 02/19/20 revealed Resident #109 was transferred to the hospital for influenza and urinary tract infections. The record had no documentation a Notice of Transfer form was completed and provided to the responsible party upon or as soon as practicable after transfer to the hospital. Interview with the Administrator on 03/12/20 at 9:45 A.M. verified the facility was unable to find documentation of a Notice of Transfer form being provided to the responsible party when Resident #109 transferred to the hospital on [DATE]. 3. Review of the medical record for Resident #18 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 01/03/2020, revealed Resident #18 had moderate cognitive impairment . Review of the medical record revealed Resident #18 was transferred to the hospital on [DATE]. The resident representative was notified by telephone. There was no evidence the resident representative received a Notice of Transfer form. Interview on 03/12/2020 at 8:45 A.M. with the Administrator verified Resident #18's resident representative did not receive a Notice of Transfer form. 4. Review of the medical record for Resident #54 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 02/19/2020, revealed Resident #54 was cognitively intact. Review of the medical record revealed Resident #54 was transferred to the hospital on [DATE], 02/09/2020 and 03/02/2020. There was no evidence Resident #54's Power of Attorney

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.

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) (POA) was given written notice of the transfer on 01/11/2020, 02/09/2020, and 03/02/20. Interview on 03/12/2020 at 8:45 A.M. with the Administrator verified Resident #18's resident representative did not receive a written notice of the transfer to the hospital. Review of the facility policy titled Transfer and Discharge, revised 01/28/2020, revealed for an emergency transfer/discharge, the facility is to provide transfer notice and bed hold policy to the resident and/or an immediate family member or legal representative.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview and policy review, the facility failed to flush a percutaneous endoscopic gastrostomy (peg) tube by gravity. This affected one (#57) of one resident observed and sampled for tube feedings out of three residents who received tube feedings. The facility census was 59. Findings include: Review of the medical record for Resident #57 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment, dated 02/27/20, revealed Resident #57 was cognitively intact . Resident #57 was noted to have a feeding tube. Review of the care plan dated 02/20/20 revealed Resident #57 had potential fluid deficit related to nothing by mouth and tube feeding. Resident #57 required a tube feeding related dysphagia pharyngeal phase, and nothing by mouth status. Review of the current physician orders [REDACTED].M. to 7;00 A.M. Flush feeding tube with 90 ml water before continuous feed. [MEDICATION NAME] 1.5 237 ml bolus three times daily, Flush feeding tube with 90 ml water prior to and after bolus feed, and flush tube feeding with 50 ml water pre/post medication administration. Observation on 03/12/20 at 7:20 A.M. revealed Registered Nurse (RN) #240 was performing peg tube site care and disconnected the tube feeding. Following the site care, RN #240 used a syringe with water and flushed the feeding tube by using the syringe plunger to push water through the peg tube instead of allowing it to flush by gravity. Interview at the time of the observation on 03/12/20 at 7:20 A.M., RN #240 verified she did not flush the peg tube by gravity, but used the plunger to bolus the flush through the syringe. Review of the policy titled Enteral Feeding Administration and Tube Flushing, revised 09/18/19, revealed to infuse physician ordered amount of water by slowly by gravity. Never force liquids.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, review of manufacturer's guidelines and facility policy review, the facility failed to administer medications to residents as ordered, which resulted in a medication error rate greater than five percent. This affected two (#56 and #26) of seven residents observed during medication administration. A total of two errors were observed out of 25 opportunities for an error rate of eight percent. The facility census was 59. Findings include: 1. Review of the medical record for Resident #56 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #56's current physician orders [REDACTED]. Observation on 03/09/2020 at 4:40 P.M. revealed RN #262 primed the [MED] [MED] pen with one unit of [MED]. RN 3262 then selected and administered four units of [MED] to Resident #56. Review of the manufacturers guidelines for administering [MED] from an [MED] pen revealed priming the [MED] pen ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime the pen before each injection, you may get too little [MED]. Step five of the recommendation notes to dial the [MED] pen to two units to prime the pen. Interview on 03/09/2020 at 4:45 P.M. with RN #262 verified he primed the [MED] pen with one unit of [MED], not the recommended two units per manufacturer's guidelines, prior to administering the [MED] to Resident #56. Review of the policy titled [MED] Administration, dated 06/21/17, revealed if using pen devices, there are several important considerations, check manufacturer instructions prior to use, as procedures may vary. Many pens require priming or an air-shot prior to administration. 2. Review of the medical record for Resident #26 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #26's current physician orders [REDACTED].M. revealed RN #208 administered Resident #26's Breo Ellipta 100/25 mcg inhaler, one puff, and then administered the resident's scheduled oral medications which were mixed with pudding. Resident #26 did not rinse his mouth with water after administration of the Breo Ellipta inhaler. Interview on 03/10/2020 at 7:40 A.M. with RN #208 verified she did not have Resident #26 rinse his mouth after administration of the Breo Ellipta inhaler as ordered. Review of the policy titled Orally Inhaled Medications, dated 07/26/18, revealed after inhalation, gargling solution will reduce drug absorption from the oral mucosa. Rinsing the mouth is most commonly recommended with long term steroid use. A total of two errors were observed out of 25 opportunities for an error rate of eight percent.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of manufacturer's guidelines, and facility policy review, the facility failed to ensure the correct dose of [MED] was administered per physician's orders [REDACTED].#56) of one resident observed to receive [MED] from an [MED] pen. The facility identified twelve residents that receive [MED] by an [MED] pen. The facility census was 59. Findings include: Review of the medical record for Resident #56 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of Resident #56's current physician orders [REDACTED]. Observation on 03/09/2020 at 4:40 P.M. revealed RN #262 primed the [MED] [MED] pen with one unit of [MED]. RN 3262 then selected and administered four units of [MED] to Resident #56. Review of the manufacturers guidelines for administering [MED] from an [MED] pen revealed priming the [MED] pen ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime the pen before each injection, you may get too little [MED]. Step five of the recommendation notes to dial the [MED] pen to two units to prime the pen. Interview on 03/09/2020 at 4:45 P.M. with RN #262 verified he primed the [MED] pen with one unit of [MED], not the recommended two units per manufacturer's guidelines, prior to administering the [MED] to Resident #56. Review of the policy titled [MED] Administration, dated 06/21/17, revealed if using pen devices, there are several important considerations, check manufacturer instructions prior to use, as procedures may vary. Many pens require priming or an air-shot prior to administration.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility Quality Assurance Performance Improvement (QAPI) plan, observations, staff interview, family interview, review of facility policy, review of Center for Disease Control (CDC) website information on Norovirus, and review of facility Norovirus Fact Sheet, the facility failed to implement the written plan QAPI plan to assist in prevention of spread of a Norovirus infection. This had the potential to affect all 59 residents in the facility. Findings include: Review of a QAPI plan dated 03/05/20 identified the facility created a plan with the targeted area of opportunity for improvement as Norovirus. The outcome/goal was identified to prevent the transmission of the spread of Norovirus. Action steps under Prevention included: Follow hand-hygiene guideline, Follow infection control policy and procedures, Follow contact precautions/isolation for those who are symptomatic with Norovirus, and Monitor CDC website for Norovirus. Under Detection-Monitoring for Potential Infectious Patients, Staff, and Visitors, the action step included: Monitoring all residents for symptoms of gastrointestinal illness. Under Triage and Isolation/Education action steps included: If a resident was suspected of Norovirus, initiate isolation contact precautions, Resident to use bedside commode if uses the bathroom toilet., Center has eliminated dining room service with meals trays delivered to rooms, and Staff will be educated on Norovirus and handwashing. Observation on 03/09/20 at 11:40 A.M. of the lunch trays being passed to resident rooms on the front hallways revealed State tested Nurse Aide (STNA) #249 went in and out of room [ROOM NUMBER] and 104, which had contact isolation signage on the doors. STNA #249 was observed taking trays into the isolation rooms without wearing any personal protective equipment (PPE), STNA #249 would exit the rooms without washing her hands and deliver another resident tray in the room, again without wearing PPE. Observation on 03/09/20 at 11:55 A.M. of the rooms for Resident #51 and Resident #02, who both tested positive for the Norovirus, revealed the residents shared the common bathroom, located between room [ROOM NUMBER] and room [ROOM NUMBER], with two other residents who did not have symptoms. No bedside commode was present in either Resident #51 or Resident #02 ' s rooms. Each room had a narrow vertical sign approximately three inches by eight inches present on the hallway side of the door frame to alert anyone who entered the rooms to see the nurse

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F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) prior to entering. An isolation cart was placed outside the resident ' s room with disposable gowns, masks and gloves available for use. During an interview on 03/09/20 at 12:00 P.M., STNA #259 verified the bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] was shared by four residents. Two of the residents were on contact precautions. She stated Resident #51 could not go into the bathroom by herself, but Resident #02 at times would take herself to the bathroom. During an interview on 03/09/20 at 12:15 P.M., the Administrator verified the toilet was used by four residents and two of the residents were able to take themselves to the bathroom and two required assistance. The Administrator verified Resident #51 shared a room with a resident who did not have symptoms of the Norovirus. Observation on 03/09/20 at 12:15 P.M. of hall tray service on the 400 Hall revealed STNA #230 entered the room of Resident #04 to deliver and set up lunch. Resident #04 had gastrointestinal symptoms and was ordered contact isolation. STNA #230 was not wearing any PPE equipment upon entering the room nor washed her hands upon exiting. Interview at the time of the observation STNA #230 verified she did not don PPE when she entered Resident #04's room or wash her hands upon exiting. She stated she did not know she needed to use PPE for meal service. Observation on 03/09/20 at 12:15 P.M. revealed STNA #230 delivered a meal tray to Resident #04 in her bedroom and STNA #239 delivered a meal tray to Resident #20 in her bedroom. Both Resident #04 and Resident #20 were observed to be on contact isolation. Resident #20 was positive for Norovirus currently. Neither STNA was wearing PPE and both failed to perform hand hygiene after exiting the room. STNA #239 removed another lunch tray from the cart. Interview at the time of the observation with Unit Manager #245 verified STNA #239 did not don PPE but should have prior to entering the room and should have washed her hands upon exiting. During an interview on 03/09/20 at approximately 12:20 P.M., STNA #230 verified she was not aware PPE needed to be worn went entering rooms of residents who were on contact isolation. During an interview on 03/09/20 at approximately 12:25 P.M., Licensed Practical Nurse (LPN) #245 stated PPE should be worn by staff anytime they enter either Resident #04 or Resident #20 ' s room. Observations on 03/09/20 at 12:30 P.M. revealed STNA #249 was removing resident lunch trays from room [ROOM NUMBER] with no gloves or other PPE in use. Observation on 03/09/20 at 12:35 P.M. revealed the main dining room was closed. Observation of the common area near the 400 Hall nurses station revealed six residents (#1, #21, #29, #35, #36, and #25) were seated at fold up tables receiving assistance from staff with eating lunch. Interview at this time with Medical Records Clerk (MRC) #219 verified six residents were eating in the common area together. Observation on 03/09/20 at 12:40 P.M. revealed Resident #10, Resident #45, Resident #14, and Resident #39 were congregated in the front lobby. Resident #45 had a lunch tray and was eating in the lobby. An interview at the time of the observation with the Assistant Director of Nursing (ADON) verified the residents were sitting together and eating in the lobby. Observation on 03/09/20 at approximately 12:40 P.M. revealed STNA #221 was removing lunch trays from room [ROOM NUMBER]. STNA #221 was not wearing gloves or PPE. She placed the lunch trays on the hall cart and then left the hall. At approximately 12:45 P.M. STNA #221 returned to the 100 Hall. During an interview at this time with STNA #221, she verified she had removed the meal trays from room [ROOM NUMBER]. STNA #221 stated she had not washed her hands when she left the room but had used alcohol gel sanitizer to cleanse her hands. STNA #109 stated she was unaware Resident #109 was on contact precautions and had been exhibiting gastrointestinal symptoms. Observation on 03/09/20 at 12:55 P.M. revealed STNA #249 entered Resident #04 ' s bedroom without any PPE in use. STNA #249 removed the meal tray from the room, placed the meal tray on the tray cart, and proceeded to enter and exit the rooms of other residents who were not on contact precautions to gather their meal trays. No hand hygiene was observed to occur at any point of this observation. During an interview on 03/09/20 at approximately 1:00 P.M., STNA #249 stated the staff were not given any education on what to do with the meal trays of the residents who ate in their rooms and were on contact precautions. STNA #249 verified she did not wear any PPE or perform hand hygiene after removing the meal tray from Resident #04 ' s room and before entering other non-symptomatic residents ' rooms to gather meal trays. During an interview on 03/09/20 at 1:00 P.M., the Administrator verified the QAPI action plan intervention to feed residents in their rooms was not being followed. During an interview on 03/09/20 at 1:30 P.M., STNA #225 stated she had been in and out of resident rooms who were on contact isolation without using PPE or washing her hands. Observation of Resident #47 on 03/09/20 at 2:00 P.M. revealed the resident had been placed in contact isolation due to gastrointestinal symptoms. Resident #47 shared a common bathroom with Resident #53, who resided in the next room. No bedside commode was observed in Resident #47 ' s room. Observation on 03/09/20 at 5:00 P.M. revealed Resident #14 and Resident #10 were observed to be served their supper trays in the front common areas. Observation on 03/10/20 at 11:40 A.M. revealed Resident #13 was served lunch in the back common area. Interview with Unit Manager #245 and MRC #219 on 03/10/20 at 11:42 A.M. verified Resident #13 was served in the common area because the resident wanted to eat there. They verified residents were to be served their meals in their rooms to try and slow the spread of the Norovirus. Observation on 03/10/20 at 12:10 P.M. revealed STNA #244 was going into the room of Resident #58 and Resident #109. STNA #244 did not don any PPE upon entering the room. Interview at the time of the observation with STNA #244 revealed she did not know she needed to wear PPE. She further stated she did not know Resident #58 was on contact precautions. During a telephone interview on 03/10/20 at 2:05 P.M., Public Health Nurse Registered Nurse (RN) #01 with the local health department, revealed the DON had contacted him on 03/06/20 around 2:30 P.M. to notify him of two positive cases of Norovirus with their residents. He indicated the facility had reported to him they had closed their dining room and were no longer having group activities. Public Health Nurse RN #01 stated he received the line listing of residents with symptoms and sent the facility a link for guidance from the Centers for Disease Control regarding long term facilities and Norovirus. He stated he encouraged the facility to use soap and water for handwashing as hand sanitizer was not effective against the Norovirus. He further stated he informed the facility to avoid having residents gather in large groups such as the dining room. Residents who were non-symptomatic should stay in their rooms with limited time out of their room. Public Health Nurse RN #1 acknowledged alcohol-based hand sanitizers were not recommended for hand hygiene when in contact with infected or symptomatic residents; instead washing hands with soap and water was recommended. During an interview with the Administrator on 03/10/20 at 3:00 P.M., he verified the QAPI plan indicated bedside commodes should have been implemented for residents who had tested positive for Norovirus or had symptoms and were able to use the toilets. The Administrator verified this had not been initiated until 03/10/20. During an interview with the Administrator on 03/10/20 at 4:00 P.M. verified Residents #10 and #14 continued to sit in the front common area much of the time and eat their meals in this area. He stated they were not willing to meet in each other ' s rooms, despite multiple attempts to educate them on the need to not be congregating in the common areas to prevent spread of the Norovirus. Observation on 03/11/20 at 3:40 P.M. revealed a family member was observed to be sitting on a chair in the room with Resident #109 with no PPE on. A sign was present on the doorframe to check with the nurse before entering and mentioned contact precautions. Interview with the family member of Resident #109 on 03/11/20 at 3:40 P.M. revealed she was informed by nursing staff on 03/10/20 she did not need to wear any PPE since her family member's Norovirus test was negative. Interview with STNA #215 on 03/11/20 at 3:43 P.M. verified she knew the family member was in the room and had no PPE on but did not think she was to tell her she needed to don PPE. Interview with LPN #251 on 03/11/20 at 3:45 P.M. verified she knew the family member was in the room, but she had been busy and had not been able to talk to the family member. Observation on 03/11/20 at 3:50 P.M. revealed a family member entered the room of Resident #34, who had tested positive for the Norovirus and was in contact precautions, without any PPE in use. During an interview with on 03/11/20 at 3:55 P.M. the Administrator revealed he had provided education to the family of Resident #34 multiple times throughout the day and they still insisted on entering the room with no PPE. During an interview on 03/12/20 at 1:30 P.M., Regional Nurse #275 verified as of 03/12/20 the facility had been 14 residents with symptoms of the Norovirus, three negative results, five positive results and six pending results, of which three specimens had not been able to be collected yet. Review of an undated facility form titled Fact Sheet Norovirus Gastroenteritis revealed personal protective equipment was to be used, including gloves and gowns for contact with body fluids or contaminated surfaces. It further revealed during outbreaks, use of soap and water was the preferred method of hand hygiene but staff could supplement with alcohol-based hand sanitizers if hands were not visibly soiled and had not come in contact with diarrhea or contaminated surfaces. Activities should be discontinued, and residents should have meals in their rooms when an outbreak is suspected. Review of facility policy titled Transmission Based Precautions (Isolation) Contact Precautions, dated 07/11/18, revealed the facility was to use contact precautions in addition to standard precautions in the care of residents known or suspected to have a serious illness easily transmitted by direct resident contact or by indirect contact with items in the resident's environment. Hand hygiene should be completed prior to donning gloves. Gloves were to be worn when entering the room and while providing care for the resident, and then removed before leaving the resident's room and hand hygiene should be performed immediately. A gown was to be donned prior to entering the room and removed before leaving the resident's room. Review of Norovirus Gastroenteritis: Management of Outbreaks in Healthcare Setting from the Centers for Diseases website, revealed in health care the most likely and common mode of transmission of Norovirus is through direct

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F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) contact with infected persons or contaminated equipment. When Norovirus is suspected hands were to be washed with soap and water after contact with symptomatic residents. Alcohol-based hand sanitizers appeared to be relatively ineffective against Norovirus. In health care settings isolation precautions is often the most effective means of stopping the transmission. Contact isolation includes the use of gown, gloves, and hand hygiene. Minimize resident movement in the facility to control the transmission. The facility identified seven residents (#02, #04, #08, #18, #20, #34, and #51) who tested positive for Norovirus, six residents (#05, #07, #23, #47, #58, and #109) who developed gastrointestinal symptoms, and ten staff members; STNA #212, STNA #221, STNA #227, STNA #233, STNA #236, STNA #247, STNA #257, STNA #261, LPN #256, and the Director of Nursing (DON), developed gastrointestinal symptoms which required time off work.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, surveyor observations, staff, resident, and family interviews, county health department staff interviews, review of the facility's Norovirus Gastroenteritis Fact Sheet, review of a Quality Assurance Performance Improvement (QAPI) Action Plan for Norovirus, review of policy and procedures for outbreak investigations, review of facility policy for contact isolation, review of the Employee Call In Log, review of the facility policy for handwashing, review of the Center for Disease Control (CDC) website information regarding the prevention of Norovirus, review of the facility policy for glucometer decontamination, and review of the manufacturer's recommendations, the facility failed to follow their policies and procedures, their QAPI action plan, and the recommendations of the CDC in regards to preventing the spread of Norovirus between residents of the facility. This resulted in an Immediate Jeopardy for seven residents (#02, #04, #08, #18, #20, #34, and #51) who tested positive for Norovirus, six residents (#05, #07, #23, #47, #58, and #109) who developed gastrointestinal symptoms, and placed 46 additional residents currently residing in the facility at serious potential risk for harm due to possible transmission of the disease. Additionally, ten staff members, State tested Nurse Aides (STNA) #212, #221, #227, #233, #236, #247, #257, #261, Licensed Practical Nurse (LPN) #256, and the Director of Nursing (DON), developed gastrointestinal symptoms which required time off work. Additionally, the facility placed the following residents at potential for harm which did not rise to the level of Immediate Jeopardy when the facility failed to ensure a glucometer was cleaned between use for two (#12 and #56) of two residents observed having fingerstick blood sugar checks, out of 19 residents in the facility who received finger stick blood sugars. Furthermore, the facility failed to cleanse scissors prior to cutting a gauze packing for an infected pressure wound during the dressing change for one (#56) of one dressing observed. The facility had six residents receiving dressing changes. The facility census was 59. On 03/11/20 at 4:00 P.M., the Licensed Nursing Home Administrator (LNHA) and Regional Nurse #275 were notified Immediate Jeopardy began on 03/05/20 when Resident #34 had a stool sample test positive for Norovirus. The facility did not implement their QAPI plan regarding the placement of individual bedside commodes for use by positively infected residents, thereby allowing the continued use of shared bathrooms, did not implement their QAPI plan to have residents eat their meals in their rooms during an outbreak of Norovirus, and did not properly educate the staff on appropriate hand hygiene to prevent further spread of the Norovirus. Observations on 03/09/20 revealed residents were still receiving meal trays in common areas, residents were still congregating together in lobby areas, staff were observed entering rooms of residents requiring contact isolation without using Personal Protective Equipment (PPE), including gloves. The staff would then be observed leaving the rooms of residents identified on contact isolation without washing their hands, proceeding into the room of residents exhibiting no symptoms. Visitors were observed to be using the incorrect PPE in rooms of residents who tested positive for Norovirus. Residents who had a positive laboratory result for Norovirus or who were symptomatic were observed to be sharing rooms and common bathrooms with residents who were without symptoms. Interviews with staff on 03/09/20 revealed many staff were unaware of which residents were positive for the Norovirus, were unaware of which residents were on isolation, and were unaware that hand sanitizer was not an effective means to cleanse hands after potential contact with Norovirus. Residents who had a positive laboratory result for Norovirus or who were symptomatic were observed to be sharing rooms and common bathrooms with residents who were without symptoms. Observations on 03/10/20 revealed residents continued to be allowed to eat and congregate in the common areas. Observations on 03/11/20 revealed visitors continued to enter rooms of residents on contact isolation for gastrointestinal symptoms without utilizing any PPE. The Immediate Jeopardy was removed on 03/11/20 at 7:20 P.M., when the facility implemented the following corrective actions: On 03/02/20 at 8:00 A.M., after identifying three residents with gastrointestinal symptoms of loose stools, the facility closed the dining room and terminated all group activities. On 03/03/20, the DON began educating nursing staff on the Norovirus, handwashing, cleaning resident items with bleach wipes, and contact isolation. On 03/04/20, the DON and Housekeeping Supervisor #500 educated all housekeeping staff on cleaning isolation rooms, the Norovirus, and [MEDICAL CONDITION] . On 03/05/20, the facility QAPI team met and developed a plan of action for Norovirus infections in the facility. On 03/06/20 at 2:30 P.M., the DON notified the local health department of two residents testing positive for Norovirus and additional residents presenting with the symptom of loose stools. On 03/06/20, the facility placed signage on entrances to the facility identifying a gastrointestinal outbreak occurred in the facility. The signage recommended visitors visit at another time. On 03/06/20, the DON/designee began conducting hand washing audits with five staff members audited. The handwashing audits continued through 03/09/20 by nursing management. The nurse management team will continue to conduct weekly audits. On 03/06/20, the DON began audits of five medical records per week for four weeks, then monthly for three months to ensure the policies and procedures regarding infection control, specifically contact precautions and hand hygiene practices are being followed. On 03/07/20, physical, occupational, and speech therapies began providing treatment in resident rooms. On 03/09/20, the Administrator and Regional Nurse #275 began in-services for all staff members on hand hygiene, disinfecting toilets after use, and glucometer disinfecting after use. On 3/11/20 at 7:20 P.M., all facility staff were provided education on change in condition, reporting and handling/monitoring the Norovirus, use of the communication binder at nurses' station to identify residents on isolation precautions and hand hygiene guidelines, meals being served in rooms only, and PPE to be worn by staff and visitors while in a resident's room who had isolation precautions in place. On 03/09/20, the facility implemented the use of bedside commodes for residents in rooms with shared bathrooms. On 03/09/20 by 8:38 P.M., residents testing positive for Norovirus or displaying gastrointestinal symptoms were moved to private rooms or were cohorted with other residents having symptoms. On 03/10/20, the facility added the precautions for the residents affected by gastrointestinal symptoms to the nursing staff communication binder. Observations on 03/10/20 at 7:30 A.M. revealed the facility had placed larger signage on the resident rooms identified to require isolation. The signage indicated what type of isolation was required and provided instructions on the PPE to be used. On 03/10/20 at 11:30 A.M., the Administrator educated Unit manager #245 and Medical Records Clerk #219 regarding residents eating in their rooms. On 03/11/20, Regional Nurse #275 assessed all residents for signs and symptoms of Norovirus. All residents identified at risk for [MEDICAL CONDITION] were placed under contact precautions. On 03/12/20, all residents identified with Norovirus symptoms (#08, #20, #34, #51, #02, #04, #05, #07, #18, #23, #47, #58, and #109) had been assessed and placed under contact precautions. On 03/12/20 between 9:00 A.M. and 3:30 P.M., interviews with STNAs #201, #206, #217, #223, #227, #233, #234, #236, #239, #247, #259, #261, LPNs #215, #242, #256, Registered Nurse (RN) #235, Unit Manager #245, and Assistant DON #264, revealed they were able to correctly able to state all residents were to eat in their rooms during the Norovirus outbreak, able to explain appropriate handwashing and not to use hand sanitizer for the Norovirus, able to identify residents with isolation precautions, and able to identify the proper use of PPE for staff and visitors. Although the Immediate Jeopardy was removed, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: 1(a). Review of Resident #34's medical record revealed an admission date of [DATE] and re-admission date of [DATE]. [DIAGNOSES REDACTED]. Review of nurse aide documentation of Resident #34's bowel movements revealed on 03/02/20, Resident #34 had one soft stool then proceeded with loose stools on 03/03/20 at 1:18 P.M., on 03/04/20 at 2:39 A.M., 1:21 P.M., and 9:23 P.M., and on 03/05/20 at 1:30 P.M. Review of a nursing progress note dated 03/03/20 at 8:05 A.M. revealed Resident #34 was on the toilet with watery stool noted. Review of a progress note dated 03/05/20, with a late entry date of 03/04/20, revealed Resident #34 was placed on contact isolation due to loose stools. Review of the nursing progress note dated 03/05/20 revealed the Nurse Practitioner assessed Resident #34 and ordered a stool test to rule out Norovirus. Review of a nursing progress note dated 03/06/20, with a late entry date of 03/05/20, revealed the Nurse Practitioner assessed Resident #34 and due to her condition sent her to the hospital for testing. Review of the care plan initiated on 03/05/20 for Resident #34 related to three loose stools within 24 hours documented interventions that included contact isolation and

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	365507	A. BUILDING _____ B. WING _____	03/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKLD DEFIANCE ILLUMINATE HC DEFIANCE	395 HARDING STREET DEFIANCE, OH 43512

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 4) instructions for staff to wear gowns and masks when changing contaminated linens, place soiled linens in bags marked biohazard, and bag and close linens tightly before taking them to laundry. The care plan also included an intervention to disinfect all equipment used before it left the room. Review of hospital laboratory (lab) results dated 03/05/20 revealed Resident #34 tested positive for Norovirus. Review of hospital documentation dated between 03/05/20 and 03/09/20 revealed Resident #34 was diagnosed with [REDACTED]. Review of a nursing progress note dated 03/09/20 revealed Resident #34 was readmitted to the facility to a private room. Review of the hospital [DIAGNOSES REDACTED].#34 had been hospitalized for [REDACTED].#34's bowel movements revealed upon Resident #34's return to the facility after hospitalization , Resident #34 was documented to have a loose stool on 03/10/20 at 9:35 A.M. Review of a physician order dated 03/10/20 revealed Resident #34 was place on contact precautions. 1(b). Review of Resident #20's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of nurse aide documentation of Resident #20's bowel movements revealed the resident had one loose stool on 03/01/20 and seven loose stools on 03/02/20. Review of a nursing progress note dated 03/02/20 documented Resident #20 continued to have loose stools. Review of the physician orders revealed on 03/02/20 the physician ordered a stool be obtained to test for Norovirus. Review of a physician order dated 03/04/20 revealed Resident #20 was placed on contact precautions. Review of nurse aide documentation of Resident #20's bowel movements revealed the resident had three loose stools on 03/03/20, one loose stool on 03/04/20, no bowel movement on 03/05/20, and one loose stool on 03/06/20. Review of lab results, dated 03/06/20, with a specimen collection date of 03/03/20, revealed Resident #20 tested positive for Norovirus. Review of a plan of care initiated on 03/06/20 revealed the resident had three loose stools in 24 hours. Interventions included contact isolation and instructions for staff to wear gowns and masks when changing contaminated linens, place soiled linens in bags marked biohazard, and bag and close linens tightly before taking them to the laundry. The care plan also included interventions to disinfect all equipment used before it left the room and to educate resident, family, and staff regarding preventive measures to contain the infection. Review of nurse aide documentation of Resident #20's bowel movements revealed the resident had two loose stools on 03/07/20, no bowel movement on 03/08/20, one loose stool on 03/09/20, and one loose stool on 03/10/20. 1(c). Review of the medical record for Resident #51 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set (MDS) 3.0 assessment, dated 02/13/20, revealed the resident had moderate cognitive deficits. The resident required limited assistance with bed mobility, transfers, walking, and dressing; was independent with locomotion and eating; and required extensive assistance with toileting and personal hygiene. Review of nurse aide documentation of Resident #51's bowel movements revealed the resident had loose stools on 02/26/20, 02/27/20, 02/28/20, 02/29/20, 03/02/20, 03/03/20, 03/06/20 and 03/09/20. Review of physician orders dated 03/04/20 revealed an order to check the resident's stool for Norovirus and other pathogens. Review of nursing progress notes dated 03/07/20 revealed a stool specimen was obtained and sent to the lab. Review of the lab results dated 03/08/20 revealed Resident #51's stool was positive for Norovirus. Review of a physician order dated 03/09/20 revealed Resident #51 was to be placed in contact isolation. 1(d). Review of Resident #08's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of nurse aide documentation on 03/01/20 at 10:00 A.M. and 11:17 A.M. revealed Resident #08 has loose stools. Resident #08 continued with loose stools on 03/02/20 at 10:33 A.M., on 03/04/20 at 11:07 A.M. and 9:48 P.M., on 03/05/20 at 2:09 A.M., at 03/07/20 at 10:01 A.M., on 03/08/20 at 5:59 A.M., and on 03/10/20 at 10:59 A.M. Resident #08 was also documented to have three soft stools on 03/09/20 at 1:07 A.M., 11:27 A.M., and at 4:28 P.M. Review of a nursing progress note dated 03/01/20 revealed a nutritional supplement and a medication were held due to Resident #08 experiencing diarrhea. A nursing progress note dated 03/06/20 revealed Resident #08's primary care physician was notified of the resident's loose stools with an order was given to check for Norovirus and place on isolation precautions. Review of lab results revealed Resident #08 had stool collected to test for Norovirus on 03/06/20. On 03/08/20 the test returned a positive result for the presence of Norovirus. Review of a physician order dated 03/09/20 revealed Resident #08 was placed on contact precautions. Review of the care plan revealed a new entry dated 03/06/20 for Resident #08 related to three loose stools within 24 hours. Interventions included contact isolation and instructions for staff to wear gowns and masks when changing contaminated linens, place soiled linens in bags marked biohazard, and bag and close linens tightly before taking them to laundry. The care plan also included an intervention to disinfect all equipment used before it left the room. 1(e). Review of the medical record for Resident #02 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of a quarterly MDS assessment, dated 0[DATE], revealed the resident had severe cognitive deficits and required extensive assistance with bed mobility, transfers, locomotion, dressing and eating. The resident was frequently incontinent of bowel and bladder. Review of nurse aide documentation revealed Resident #02 had loose stools on 02/28/20, 02/29/20, 03/01/20, 03/02/20, 03/03/20, 03/04/20, 03/05/20, 03/06/20 and 03/09/20. Review of physician orders dated 03/04/20 revealed an order to obtain a stool sample for Norovirus and contact isolation. Review of progress notes dated 03/09/20 revealed Resident #02 was moved to a private room. Review of the lab results dated 03/10/20 revealed Resident #02 tested positive for the Norovirus. 1(f). Review of the medical record for Resident #18 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 01/03/2020, revealed Resident #18 had cognitive impairment. Resident #18 required extensive assistance with one person assist for bed mobility, transfer, dressing, toilet use, and personal hygiene. Review of nurse aide documentation from 03/01/20 through 03/09/20 revealed Resident #18 had been having soft stools. During an interview on 03/09/20 at 9:36 AM., Resident #18 stated he had diarrhea for three days. Staff were alerted to the resident's statement. Review of the physician orders dated 03/09/20 revealed an order for [REDACTED]. Review of the lab results dated 03/12/20 revealed Resident #18 was positive for Norovirus. 1(g). Review of the medical record for Resident #04 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of a quarterly MDS assessment, dated 02/25/20, revealed the resident had no cognitive deficits. Review of nurse aide documentation revealed Resident #04 had loose stools on 03/03/20, 03/06/20 and 03/09/20. Review of a physician order dated 03/07/20 revealed the resident was placed in contact isolation. On 03/11/20, a physician order was obtained to collect a stool specimen for a Norovirus check. The stool sample was obtained on 03/11/20. Review of the lab results dated 03/13/20 revealed Resident #04 was positive for the Norovirus. 1(h). Review of the medical record for Resident #07 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 12/09/19, revealed the resident was dependent for transfers and required extensive assistance with bed mobility. Review of nursing progress notes dated 02/28/20 and 02/29/20 revealed the resident had loose stools. Review of nurse aide documentation revealed Resident #07 had three loose stools on 02/28/20, two loose stools on 02/29/20, one loose stool on 03/01/20, three loose stools on 03/02/20, two loose stools on 03/03/20, three loose stools on 03/05/20, three loose stools on 03/06/20, one loose stool on 03/07/20, one loose stool on 03/08/20, two loose stools on 03/09/20, three loose stools on 03/10/20, and two loose stools on 03/11/20. Review of the physician order dated 03/06/20 revealed an order was obtained to place Resident #07 in contact isolation. On 03/10/20 a physician order was received to check the resident ' s stool for Norovirus. Review of the lab test dated 03/10/20 revealed Resident #07 was negative for Norovirus. 1(i). Review of the medical record for Resident #109 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE]. [DIAGNOSES REDACTED]. Review of the five day MDS assessment, dated 02/28/20, revealed Resident #109 had memory deficits. The resident required extensive assistance with bed mobility, transfers, locomotion, dressing, toileting and hygiene. The resident was always incontinent of bowel. Review of nurse aide documentation revealed Resident #109 had loose stools on 03/04/20, 03/05/20, 03/06/20, 03/08/20, 03/09/20, 03/10/20, and 03/11/20. Review of physician orders dated 03/06/20 revealed the physician ordered a stool specimen to test for Norovirus and an order for [REDACTED].#109's stool sample was negative for Norovirus. 1(j). Review of Resident #23's medical record revealed an admission date of [DATE] and a re-admission date of [DATE]. [DIAGNOSES REDACTED]. Review of nurse aide documentation revealed Resident #23 had a loose stool on 03/05/20 at 1:51 P.M. Resident #23 continued with loose stools on 03/06/20 at 1:54 P.M., 1:59 P.M., and 9:28 P.M., on 03/07/20 at 1:59 P.M., on 03/09/20 at 8:43 P.M., and on 03/10/20 at 1:39 P.M. Review of nursing progress notes dated 03/06/20 revealed Resident #23 reported three loose stools. The physician was notified, and an order was given for Resident #23's stool to be tested for Norovirus. Review of a physician order dated 03/06/20 revealed Resident #23's stool was to be tested for Norovirus. A physician order was written on 03/07/20 for Resident #23 to be on contact isolation. Review of lab results dated 03/08/20 revealed Resident #23's stool was negative for Norovirus. 1(k). Review of the medical record for Resident #58 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of the admission MDS assessment, dated 02/28/20, revealed Resident #53 had moderate cognitive deficits. The resident was independent with bed mobility, transfers, walking, locomotion, eating, and toileting; was supervised with eating; and required limited assistance with personal hygiene. Review of nurse aide documentation from 02/29/20 through 03/09/20 revealed Resident #58 had loose stools on 02/29/20 and soft stools on other

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) days, except for 03/02/20, when there was no stool. Interview with Resident #58 on 03/09/20 at 10:00 A.M. revealed the resident complained of loose stools. The resident was encouraged to notify facility staff, which she did. Further review of the medical record revealed a physician order dated 03/09/20 for contact isolation and to obtain a stool specimen to check for Norovirus. Review of the lab report dated 03/16/20 revealed Resident #58 was negative for Norovirus. 1(l). Review of Resident #05's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of nurse aide documentation revealed Resident #05 had three loose stools noted on 03/09/20 at 10:42 A.M., 3:59 P.M., and 8:08 P.M. Resident #05 had no documented bowel movements between 03/10/19 and 03/12/20. Review of physician orders dated 03/09/20 revealed Resident #05 may be checked for Norovirus and contact precautions were ordered. Review of a care plan dated 03/09/20 revealed Resident #05 had signs and symptoms of an infection with at least three loose stools. Interventions included for staff to educate Resident #05 and family on the infection process, risk factors, any precautions necessary to prevent transmission and initiate contact isolation. Review of a lab result dated 03/16/20 revealed the resident was negative for Norovirus. 1(m). Review of the medical record for Resident #47 revealed the resident was admitted to the facility on [DATE] with a readmission on 11/06/19. [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment, dated 02/14/20, revealed the resident had no cognitive deficits. The resident required extensive assistance with bed mobility and toileting, limited assistance with transfers, walking, dressing, and personal hygiene. The resident was always continent of bowel. Review of progress notes dated 03/09/20 at 8:00 P.M. revealed the resident reported three loose stools had occurred on that day and an order was received to check the stool for Norovirus. Review of physician orders dated 03/09/20 revealed the resident was to be placed in contact isolation and to obtain a stool sample to check for Norovirus. Review of the lab results dated 03/12/20 revealed the resident was negative for Norovirus. Review of nurse aide documentation revealed Resident #48 had a loose stool on 03/04/20. No further loose stools were documented, and no stools were documented at all on 03/10/20. Review of an employee call in log revealed ten staff members reported signs and symptoms of Norovirus and were unable to work. On 03/03/20, STNA #227 called off work reporting a fever. On 03/04/20, STNA #212 called off work reporting nausea, vomiting, and diarrhea. On 03/05/20, STNA #261 and STNA #221 called off work for nausea, vomiting, and diarrhea. On 03/07/20, LPN #256 called off work reporting nausea, vomiting, and diarrhea. On 03/08/20, STNA #257 called off work reporting nausea, vomiting, and diarrhea. On 03/09/20, STNA #247, STNA #233, and the DON all called off work reporting nausea, vomiting, and diarrhea. On 03/10/20, STNA #236 was sent home from work after experiencing three episodes of diarrhea within two hours of starting work. Review of an in-service sheet for staff, dated 03/02/20, revealed staff were instructed the best prevention for stopping the spread of the gastrointestinal symptoms was handwashing and use of alcohol-based sanitizer. Review of a QAPI plan, dated 03/05/20, revealed staff were to follow hand-hygiene guidelines, follow infection control policy procedures and follow contact precautions. If there was suspicion of Norovirus, isolation contact precautions were to be initiated. Residents with symptoms or suspected of carrying [MEDICAL CONDITION] and able to use the toilet in the bathroom were to use individual bedside commodes. Stool samples were to be obtained. It further indicated the facility had eliminated dining room service and resident meal trays were to be delivered to their rooms. No group or therapy activities would be provided. Observation upon entering the facility on 03/09/20 at 8:00 A.M. revealed signage on the door, with a date of 03/06/20, indicating the facility was experiencing a gastrointestinal outbreak and to consider visiting later. The signage indicated handwashing and hand sanitizer was encouraged at this time. Interview with Regional Nurse #275 and the Administrator on 03/09/30 at 9:48 A.M. revealed the facility had two residents who had tested positive for Norovirus (#34 and #20). The Administrator stated the first resident had loose stools on 02/29/20 and the first positive test for Norovirus was noted on 03/05/20 when they received a call from the hospital regarding Resident #34's stool testing positive. The Administrator stated the DON spoke with the local health department and started educating staff about handwashing and the Norovirus, placed residents in isolation if they were symptomatic, initiated no congregate dining or activities, and placed signs for education throughout the facility. The Administrator stated housekeeping staff were educated on cleaning the rooms with bleach, as well as cleaning the hallways, common areas, handrails and doorknobs at least daily. He stated at this time, two residents had pending test results for Norovirus and three residents had returned negative results even though they were symptomatic. He further stated three staff had called off due to symptoms and were not to return to work until they had been symptom free. Observations of the front common area on 03/09/20 between 8:15 A.M. and 4:00 P.M. revealed Resident #10 and Resident #14 were sitting together most of the day at a table. Various other residents were observed congregating in the front lobby with Resident #10 and Resident #14 at the table or in the front common area (100/200 Halls) during additional random observations on 03/09/20. During an interview with the Assistant DON (ADON) on 03/09/20 at 1:00 P.M., she verified residents were congregated together in the front common area. Observation on 03/09/20 at 10:00 A.M., revealed Resident #58, who complained of having loose stools during an interview, resided in room [ROOM NUMBER] A. Resident #58 was observed to share a room with Resident #109, who was exhibiting gastrointestinal symptoms. Resident #109 was unable to use the toilet and was noted to be on contact isolation. room [ROOM NUMBER] was observed to share a common bathroom with room [ROOM NUMBER], thereby Resident #58, who was able to toileted herself, shared the bathroom with Resident #23, who was exhibiting gastrointestinal symptoms, and Resident #46. No bedside commodes were observed to be available for use in either room [ROOM NUMBER] or room [ROOM NUMBER]. A narrow vertical sign approximately three inches by eight inches was present on the hallway side of the door frames to alert anyone who entered the rooms to see the nurse prior to entering. A single isolation cart was placed in the hall between the two rooms. The cart contained disposable gowns, masks and gloves available for use. There was no way to identify who required the isolation. Observation on 03/09/20 at 11:02 A.M. of Resident #20's room revealed a family member exiting the resident's bathroom. The family member was wearing a face mask but no other PPE. A cart with PPE was located outside the door of Resident #20's room. Interview at the time of the observation with the family member of Resident #20 revealed the cart with PPE outside the door was for some infection the resident had, but she did not know for what infection. Interview with STNA #244 on 03/09/20 at 11:20 A.M. revealed she had been informed to wash her hands or use hand sanitizer when caring for residents with Norovirus. Interview with LPN #204 on 03/09/20 at 11:23 A.M. revealed she was unaware residents were not to eat in the common areas of the building but knew the dining room was closed. Observation on 03/09/20 at 11:40 A.M. of the lunch trays being passed to resident rooms on the front hallways revealed STNA #249 went in and out of room [ROOM NUMBER] and 104, which had contact isolation signage on the doors. STNA #249 was observed taking trays into the isolation rooms without wearing any PPE. STNA #249 would exit the rooms without washing her hands and deliver another resident tray in the room, again without wearing PPE. Observation on 03/09/20 at 11:55 A.M. of the rooms for Resident #51 and Resident #02, who both tested positive for the Norovirus, revealed the residents shared the common bathroom, located between room [ROOM NUMBER] and room [ROOM NUMBER], with two other residents who did not have symptoms. The toilet in the bathroom had and elevated toilet seat insert attached. On the inside of the seat riser was a brown dried substance. Resident #51 and Resident #02 each shared a room with a resident who had no symptoms of the Norovirus. No bedside commode was present in either Resident #51 or Resident #02's room
F 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility policy, review of the Centers for Disease Control and Prevention's (CDC) immunization recommendations, and staff interview, the facility failed to offer recommended pneumococcal vaccinations to one (#20) of five residents reviewed for pneumococcal vaccinations. The facility census was 59. Findings include: Review of Resident #20's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of immunization records for Resident #20 revealed the resident received one dose of pneumococcal conjugate (PCV13) on 10/27/85. The record was silent for any additional pneumococcal vaccinations or documentation of it being offered to Resident #20. Review of the facility policy titled Immunizations-Pneumococcal, dated 07/01/18, revealed upon admission, residents would be assessed for eligibility to receive the pneumococcal vaccine and when indicated, would be offered the vaccination, unless medically contraindicated or the resident had already been vaccinated. The policy further stated administration of the pneumococcal vaccination or revaccination would be made in accordance with the current CDC recommendations at the time of the vaccination. Review of the CDC's guideline titled Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal [MEDICATION NAME] Vaccine Among Adults Aged > [AGE] years: Updated Recommendations of the Advisory Committee on Immunization Practices, dated 11/22/19, revealed in 2014, the Advisory Committee on Immunization Practices (ACIP) recommended 13-Valent Pneumococcal Conjugate (PCV13) in series with 23-valent [MEDICATION NAME] vaccine (PPSV23) for all adults aged 65 and older. The 11/22/19 update revealed the ACIP recommended a routine single dose of PPSV23 for all adults aged 65 and older. Further review revealed if a decision was made to administer a dose of PCV13, PCV13 should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365507	A. BUILDING _____ B. WING _____	**03/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKLD DEFIANCE ILLUMINATE HC DEFIANCE	**395 HARDING STREET DEFIANCE, OH 43512**

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 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) administered first, followed by a dose of PPSV23 at least one year later for adults aged 65 and older. Interview on 03/12/20 at 2:30 P.M., the Assistant Director of Nursing (ADON) confirmed Resident #20 had only received the one dose of PCV13. Further interview on 03/12/20 at 3:10 P.M. of ADON #264 verified the facility had not offered the PPSV23 vaccination to Resident #20.