STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365250	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BUCKEYE CARE AND REHABILITATION	1900 EAST MAIN STREET LANCASTER, OH 43130

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** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview and Centers for Disease Control (CDC) guidance, the facility failed to ensure staff appropriately utilized personal protective equipment (PPE) in non-patient care areas on the facility Main Unit. In addition, the facility failed to ensure staff utilized proper infection control practices when the same staff were passing breakfast meals to residents exposed to coronavirus (COVID-19) before passing meal trays to residents not exposed to [MEDICAL CONDITION] to prevent the spread of COVID-19. This had the potential to affect all 13 residents (#2, #3, #4, #5, #6, #7, #8, #9, 10, #12, #13, #14 and #15) on the Main Unit and the potential to affect 21 residents (#16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39 and #40) of 24 residents on the Maple Unit who were not designated as being exposed to the COVID-19 virus. The census was 67. Findings include: 1. An observation and interview on 09/16/20 at 7:52 A.M. revealed Registered Nurse/Unit Manager #101 on the Main Unit utilizing her N-95 face mask with the bottom strap dangling under her chin. The observation was confirmed with Unit Manager #101 at the time of the observation and she stated when she has the bottom strap on, the mask cuts off her breathing. The Main Unit housed no residents with current infection precautions. An observation and interview on 09/16/20 at 7:55 A.M. revealed Housekeeper #102 on the Main Unit with her N-95 face mask resting under her chin, exposing her mouth and nose. Housekeeper #102 was utilizing a face shield and immediately reapplied her N-95 mask correctly. The Main Unit housed no residents with current infection precautions. Interview on 09/14/20 at 3:25 P.M. with Unit Manager # 101 revealed since the facility had COVID-19 positives, they were required to wear N-95 masks throughout the facility. Record review revealed there were 13 residents, Resident #2, #3, #4, #5, #6, #7, #8, #9, 10, #12, #13, #14 and #15 on the Main Unit. Review of CDC guidance titled, Facemask Do's and Don'ts for Healthcare Personnel, dated 06/02/20 revealed the elastic bands should be secure around your ears, and it should be secure around the middle of your head and the base of your head. It further states when wearing a facemask, don't wear it under your nose or mouth and don't allow the straps to hang down. 2. An observation on 09/16/20 from 8:00 A.M. through 8:30 A.M. revealed the Director of Nursing (DON), Infection Preventionist/Licensed Practical Nurse (LPN) #103, and Registered Nurse Unit Manager #101 passing breakfast trays on the Washington Unit (housing residents exposed to COVID-19) and then passing breakfast trays to the Maple Unit (housing 21 residents, Resident #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #30, #31, #32, #33, #34, #35, #36, #37, #38, #39 and #40 not exposed to COVID-19 and three residents (Resident #27, #28 and #29) who were exposed and residing on the unit, but separated). An interview on 09/16/20 at 9:05 A.M. with the DON confirmed the above observation. An interview on 09/16/20 at 9:00 A.M. with the Administrator revealed he did not think that was an appropriate infection control practice for the same staff to pass trays on an exposed COVID-19 unit, then pass trays on a unit housing residents that were not exposed to [MEDICAL CONDITION]. He stated it would be more appropriate to pass trays on the non-exposed units first, then go to the exposed unit last to decrease possible exposure.

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