STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365640	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF MIAMISBURG	450 OAK RIDGE BOULEVARD MIAMISBURG, OH 45342

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, staff interview, and review of facility policy, the facility failed to wear proper personal protective equipment when entering a room for two (#55 and #66) residents who were in airborne/droplet isolation. This had the potential to affect a total of seven residents on the 600 Hallway (#46, #48, #50, #52, #54, #55 and #56) and a total of eight residents on the 400 Hallway (#58, #61, #63, # 64, #66, #68, #70 and #72). The in-house census was 80. Findings include: 1. Review of the medical record for Resident #55 revealed an admission to the facility on [DATE] with re-entry 07/07/20. [DIAGNOSES REDACTED]. Review of Resident #55's physician's orders [REDACTED].M. revealed Resident #55 in his room asleep and Speech Therapist #99 sitting in a chair across from the foot of the bed charting. The threshold of the door into Resident #55's room had an isolation cart with disposable personal protective equipment. Speech Therapist #99 came out of Resident #55's room wearing a face shield, goggles and a N95 (a respiratory protective face mask to help reduce exposure to airborne particles including very small particles and large droplets) face mask. Speech Therapist #99 was not observed wearing a gown or gloves. Interview on 07/15/20 at 12:25 P.M.,Speech Therapist #99 stated the resident was asleep and she was just charting. Speech Therapist #99 stated she didn't know anything about isolation and verified she was not wearing a gown or gloves while in the resident's room. 2. Review of the medical record for Resident #66 revealed she was admitted [DATE]. [DIAGNOSES REDACTED]. Review of her physician's orders [REDACTED]. Observation on 07/15/20 at 12:21 P.M. revealed the door to Resident #66's room was closed and an isolation cart with disposable personal protective equipment was at the entrance into the room. State tested Nurse Aide (STNA) #5 was observed to open the closed door of Resident #66's room, enter through the door a few steps, wearing only goggles and an N95 face mask and yelled out to the staff person inside the room to ask if they needed help before turning around and exiting out the door. Interview on 07/15/20 at 12:21 P.M., STNA #5 verified Resident #66 was in isolation. STNA #5 stated she was not doing anything, she just went inside the room to ask if the staff member inside needed any help. STNA #5 verified she had no gown or gloves on when she walked into the room a few steps before coming out of the room. Interview on 07/15/20 at approximately 11:55 A.M. with Nurse Practitioner (NP) #250 stated her she has had to remind agency staff to pull up their mask or make sure they had on the right personal protective equipment while working with residents. Interview on 07/15/20 at 12:45 P.M., the Director of Nursing (DON) stated any time staff went into an isolation room the expectation was staff were to wear a gown, gloves, goggles and/or a face shield. Review of the Infection Control Manual Chapter 2 titled Practice Guidelines (not dated) revealed for airborne/droplet precautions staff should follow standard precautions and also wear a mask (N95 for airborne precautions), gloves and goggle if there was likelihood of exposure during care. Standard precautions indicates a gown should be worn to protect skin and prevent contamination of clothing. The facility identified seven residents on the 600 Hallway (#46, #48, #50, #52, #54, #55 and #56) and a total of eight residents on the 400 Hallway (#58, #61, #63, # 64, #66, #68, #70 and #72) where Resident #55 and Resident #66 resided.

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