| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366123 | A. BUILDING _____ B. WING _____ | 08/18/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| ACCORD CARE COMMUNITY ORRVILLE LLC | 1980 LYNN DRIVE ORRVILLE, OH 44667 |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review, and review of Nursing Home guidance from the Centers for Disease Control and Prevention (CDC), the facility failed to ensure staff were properly trained and updated on policies and procedures for COVID-19 and failed to ensure infection control policies and procedures were in place and maintained to prevent COVID-19 transmission and for appropriate contact tracing. This affected 21 residents, Resident #1, #6, #7, #12, #14, #16, #19, #32, #33, #38, #39, #41, #42, #44, #46, #47, #48, #49, #51, #55, and #58 and had the potential to affect all 58 residents residing in the facility. Findings include: 1. Resident #16 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #16's annual Minimum Data Set ((MDS) dated [DATE] revealed his cognition was severely impaired, he was totally dependant on staff for locomotion and required extensive one person assistance for eating. Observation on 08/17/20 at 8:44 A.M. revealed multiple residents in a common area eating or had already finished eating breakfast and were still seated at the table. At one folding rectangular table, there were three residents, including Resident #16, that were not socially distanced as required. State tested Nursing Assistant (STNA) #102 was assisting one of the residents at the table eating. Interview with Director of Nursing (DON) at the time of the observation confirmed residents should be socially distanced while eating in a shared area and verified Resident #16 was not at least six feet apart from other residents. Interview on 08/17/20 at 10:02 A.M. with STNA #102 revealed she was contracted through a staffing agency and had worked at this facility two times. STNA #102 revealed she had been educated about COVID-19 through the staffing agency but had not been in-serviced by the facility regarding facility specific COVID-19 or infection control policies and procedures. STNA #102 revealed she was not told residents had to be at least six feet apart during communal dining, as she was the STNA assisting residents in the communal dining area on this day at breakfast. 2. Resident #6 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #6's quarterly MDS dated [DATE] revealed the resident's cognition was severely impaired and they required extensive assistance from staff with locomotion and eating. Observation on 08/17/20 at 8:44 A.M. revealed multiple residents in a common area eating or had already finished eating breakfast and were still seated at the table. At one folding rectangular table, there were three residents, including Resident #6 that were not socially distanced. STNA #102 was assisting one of the residents at the table eating. Interview with Director of Nursing (DON) at this time confirmed residents should be socially distanced while eating in a shared area and that Resident #6 was not at least six feet apart from other residents. Interview on 08/17/20 at 10:02 A.M. with STNA #102 revealed she was contracted through a staffing agency and had worked at this facility two times. STNA #102 revealed she had been educated about COVID-19 through the staffing agency but had not been in-serviced by the facility regarding facility specific COVID-19 or infection control policies and procedures. STNA #102 revealed she was not told residents had to be at least six feet apart during communal dining, as she was the STNA assisting residents in the communal dining area on this day at breakfast. 3. Resident #7 was admitted on [DATE] with [DIAGNOSES REDACTED].#7's quarterly MDS assessment dated [DATE] revealed her cognition was severely impaired and she required staff supervision with locomotion and eating. Observation on 08/17/20 at 8:44 A.M. revealed multiple residents in a common area eating or had already finished eating breakfast and were still seated at the table. At one folding rectangular table, there were three residents, including Resident #7 that were not socially distanced. STNA #102 was assisting one of the residents at the table eating. Interview with Director of Nursing (DON) at this time confirmed residents should be socially distanced while eating in a shared area, and Resident #7 was not at least six feet apart from other residents. Interview on 08/17/20 at 10:02 A.M. with STNA #102 revealed she was contracted through a staffing agency and had worked at this facility two times. STNA #102 revealed she had been educated about COVID-19 through the staffing agency but had not been in-serviced by the facility regarding facility specific COVID-19 or infection control policies and procedures. STNA #102 revealed she was not told residents had to be at least six feet apart during communal dining, as she was the STNA assisting residents in the communal dining area on this day at breakfast. 4. Resident #12 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #12's quarterly MDS assessment dated [DATE] revealed she was alert and oriented and her cognition was intact. She required staff supervision with activities of daily living. Record review for revealed a physician order for [REDACTED].#12's August 2020 Medication Administration Record [REDACTED]. Observation on 08/17/20 at 8:44 A.M. revealed multiple residents in a common area eating and residents that were finished eating but still there were not wearing any type of mask. Observation on 08/17/20 at 9:03 A.M. revealed Resident #12 was walking with a walker to the common area without wearing a mask. No staff were observed encouraging her to wear a mask. Interview on 08/17/20 at 9:13 A.M. with Resident #12 revealed she wondered why residents were not wearing masks. She said she had two masks but they were taken away from her. Resident #12 felt the residents should have masks on as they are at the facility to recover. Observation of her room, with Resident #12 present, revealed no masks available for her to use when leaving her room. Interview on 08/17/20 at 10:02 A.M. with STNA #102 revealed she was contracted through a staffing agency and had worked that the facility two times. STNA #102 revealed she had been educated about COVID-19 through the staffing agency but had not been in-serviced by the facility regarding facility specific COVID-19 or infection control policies and procedures. STNA #102 revealed she had assisted all but two residents up on the wing to get up that morning. She said Resident #12 resided on the unit she was assigned to and she verified she did not encourage any resident to wear a face mask. STNA #102 revealed she was only told to encourage residents to wear masks when they have an outside visit. 5. Interview on 08/17/20 at 8:53 A.M. with the DON revealed newly admitted residents were to be quarantined for 14 days, regardless of their COVID 19 status. The DON revealed the residents on D wing were newly admitted from another nursing facility that had recently closed and were quarantined there. The DON also said residents had the right to decline wearing a mask and if they refused, staff should document the reason why. Resident #51 was admitted on [DATE] to the D wing from another facility. [DIAGNOSES REDACTED]. Resident #51's Daily MDS note dated 08/09/20 revealed he was alert and oriented, was easily distracted, and required supervision with locomotion on the unit. Review of Resident #51's most recent COVID-19 laboratory results dated [DATE] revealed the resident was negative for COVID-19 prior to coming to this facility. Resident #55 was admitted on [DATE] to the D wing from another nursing facility with [DIAGNOSES REDACTED]. Resident #55's Daily MDS note dated 08/11/20 revealed the resident was alert, oriented to person, confused, easily distracted, and independent for mobility Review of Resident #58's most recent laboratory results dated [DATE] revealed the resident was negative for COVID-19. Resident #58 was admitted on [DATE] to the D wing from another nursing facility with [DIAGNOSES REDACTED]. Resident #59's daily MDS note dated 08/09/20 revealed the resident was alert and oriented, was easily distracted, and was independent in locomotion on the unit. Review of Resident #58's most recent laboratory results dated [DATE] revealed the resident was negative for COVID-19. Observation on 08/17/20 at 10:30 A.M. revealed the facility D wing's doors were closed. Upon entering the D wing, the therapy room was located to the left as you walk onto the unit. Resident #55, Resident #51, and Resident #58 were observed in the common area right past the therapy room without masks on and were socializing with each other. STNA #100 was in the common area helping the residents, and the only personal protective equipment (PPE) worn was a KN95 mask. She did not wear a gown, goggles/face shield, or gloves as required while working with residents in a quarantine unit. |

| 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366123 | A. BUILDING _____ B. WING _____ | 08/18/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| ACCORD CARE COMMUNITY ORRVILLE LLC | 1980 LYNN DRIVE ORRVILLE, OH 44667 |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 1)<br>Interview on 08/17/20 at 11:45 A.M. with STNA #100 revealed she was an agency staff member and the facility had not reviewed any COVID-19 specific protocols for the facility. She said she was updated on information when making rounding with other STNA's. STNA #100 revealed the residents are encouraged to wear masks on D wing, but they will not keep them on. STNA #100 verified Resident #55, who was not wearing a mask, wanders and goes up to the door near the entrance to the unit which is also by the therapy room. Interview on 08/17/20 at 1:32 P.M. with the DON confirmed residents in the general population enter the D wing to use the therapy room. The DON verified residents on D wing are in quarantine but do not stay in their rooms or wear masks per their preference. The facility provided a list of 10 residents from the general population that go to the therapy room on the D wing, quarantine unit, and would be exposed to the residents on this unit who were not staying in their rooms and were not wearing masks while out of their rooms. These residents were Resident #1, Resident #7, Resident #14, Resident #19, Resident #32, Resident #33, Resident #38, Resident #39, Resident #46, and Resident #48. Interview on 08/17/20 at 3:00 P.M. with the Administrator revealed new admissions in the facility have had negative COVID-19 tests therefore full personal protective equipment is not needed in those rooms and the residents are quarantined in their rooms for 14 days. The Administrator said staff entering quarantine rooms only needed to wear a surgical mask, which is not in accordance with guidance from the Centers for Disease Control and the facility policy. Review of the facility policy titled, New Admission/Re-Admission COVID-19 Prevention, revealed the facility would create a plan for managing new admissions and readmissions whose COVID-19 status was unknown and options included placement in a single room or in a separate observation area so the residents can be monitored for evidence of COVID-19. All recommended COVID-19 PPE should be worn during care of these residents under observation, which includes us of an N95 or higher level respiratory mask, eye protection, gloves, and gown. Review of the CDC guidance updated 07/15/20 revealed recommended infection prevention and control practices when caring for a patient with unknown, suspected or confirmed [DIAGNOSES REDACTED]-CoV-2<br>(COVID-19) infection as a measure to limit healthcare personnel exposure and conserve PPE included to consider designating entire units within the facility, determine how staffing needs would be met as the number of patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection increases and if healthcare personnel become ill and were excluded from work. Limit transport and movement of the patient outside of the room to medically essential purposes. In regards to PPE, healthcare personnel who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher level respirator, gown, gloves and eye protection. Personal protective equipment training, on understanding and demonstrate when to use PPE, what PPE was necessary, how to properly apply (don), use and remove (doff) PPE in a manner to prevent self-contamination, how to properly dispose or disinfect and maintain PPE and the limitations of PPE should be completed. 6. Observation on 08/17/20 at 1:00 P.M. revealed there was a sign on Resident #44's door for staff to sign when they enter the resident's room. STNA #103 was observed entering and exiting the room and did not sign the form. Interview with STNA #103 at this time revealed all staff are to sign if they go in the room for COVID-19 tracking purposes. STNA #103 reviewed the sign-in sheet from 08/10/20 through 08/17/20 and verified there were no staff sign-ins records for 08/13/20, 08/15/20, and 08/16/20, confirming staff were not signing it daily as required. On 08/11/20 and 08/14/20, housekeeping staff were the only staff that signed the form. This concern was discussed during an interview on 08/17/20 at 1:32 P.M. with the DON. The DON revealed their should be a sign-in form on each resident's room for staff to sign when they entered the resident's room. This is to help trace staff who have had contact with a resident if they end up testing positive for COVID-19. 7. Observation on 08/17/20 at 1:00 P.M. revealed several resident rooms had welcome signs near their room number and name plate. STNA #103 revealed she is updated during daily rounds of residents who are on quarantine as there is no signage or posting to identify which residents were in quarantine. STNA #103 revealed Resident #44, Resident #47, Resident #49, Resident #48, Resident #42, and Resident #41 were all in quarantine. Interview on 08/17/20 at 1:32 P.M. with the DON revealed Resident #44, Resident #47, Resident #48, Resident #42, and Resident #41 were in quarantine because they were admitted within the last 14 days. The DON said Resident #49 was no longer in quarantine as indicated by STNA #103. The DON had to review the resident's admitted s in each of their hard charts in order to determine if they were still supposed to be in quarantine or not. The DON confirmed there was no signage to alert staff or visitors that these residents were in quarantine or as to what type of PPE should be worn. Review of the CDC guidance updated 07/15/20 revealed recommended infection prevention and control practices when caring for a patient with unknown, suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 (COVID-19) infection as a measure to limit healthcare personnel exposure and conserve PPE. In regards to PPE, healthcare personnel who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection<br>should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher level respirator, gown, gloves and eye protection. 8. Interview on 08/17/20 at 10:02 A.M. with STNA #102 revealed she was contracted through a staffing agency and had worked at this facility two times. STNA #102 revealed she had been educated about COVID-19 through the staffing agency but had not been in-serviced by the facility regarding facility specific COVID-19 or infection control policies and procedures. STNA #102 said she had gotten all but two residents up on the wing she was assigned to and verified she had not encouraged any resident to wear a face mask when coming out of their room. STNA #102 revealed she was only told to encourage residents to wear face masks when they have an outside visit. Interview on 08/17/20 at 10:40 A.M. with the Administrator revealed the facility provided staff with COVID-19 updates via a bulletin board with information in the break room, via text messages, and verbal communication. The Administrator revealed they do not have staff sign anything to indicate they have read and received the updates since inservices were conducted with the facility staff in April and May 2020. The Administrator verified agency staff received no formal inservices related to COVID-19 policiies and procedures and only received information from other floor staff during their shift. Interview on 08/17/20 at 11:45 A.M. with STNA #100 revealed she was contracted through a staffing agency and had been educated about COVID-19 through the staffing agency but had not been in-serviced by the facility regarding facility specific COVID-19 or infection control policies and procedures. Observation on 08/17/20 at 1:32 P.M. revealed the break room had COVID-19 information posted, including a memo that said residents must be provided with one mask and they should wear it when they are in the common areas/participating in activities. There was no way to verify any staff had read the posted memo. Review of the CDC guidance updated 07/15/20 revealed recommended infection prevention and control practices when caring for a patient with unknown, suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 (COVID-19) infection as a measure to limit healthcare personnel<br>exposure and conserve PPE included to consider designating entire units within the facility, determine how staffing needs would be met as the number of patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection increases and if healthcare personnel become ill and were excluded from work. Limit transport and movement of the patient outside of the room to medically essential purposes. In regards to PPE, healthcare personnel who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved<br>N95 or equivalent or higher level respirator, gown, gloves and eye protection. Personal protective equipment training, on understanding and demonstrate when to use PPE, what PPE was necessary, how to properly apply (don), use and remove (doff) PPE in a manner to prevent self-contamination, how to properly dispose or disinfect and maintain PPE and the limitations of PPE should be completed. This deficiency substantiates Complaint Number OH 923. |