STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365644	A. BUILDING _____ B. WING _____	06/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINCHESTER CARE & REHABILITATION	36 LEHMAN DR CANAL WINCHESTER, OH 43110

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 0800 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.** Based on observation, review of menu and dietary spreadsheet, and staff interview the facility failed to provide residents with appropriate portion sizes according to the spreadsheet for residents on pureed diets. This affected three residents on the B hall (Residents #18, #42 and #94). The facility census was 118. Findings include: Observations on 06/11/20 at 12:00 P.M. revealed trays were being passed to residents. The dietary manager (DM) #13 was present to take temperatures of the food on the cart. He removed the food from the cart at the beginning of the tray pass. Only one tray had been removed prior to this observation. The meal was in a Styrofoam to go container. The container was opened and contained pureed Lasagna and pureed vegetables and no other food. Both meal entrees appeared to be extra small portions. It appeared to be 3-4 tablespoons of each. When questioning DM #13, he stated the residents had been not feeling well and hadn't been eating well so he decided not to send as much food. DM #13 stated this was his decision to make and verified the residents should have been served the entire portion unless the resident requested something different. At this time, DM #13 and the surveyor took the food back to the kitchen to observe the actual portion size. DM #13 stated the amount served should have been four ounces. Review of the spreadsheet for the meal determined the amount to be served was six ounces of lasagna and 1/2 cup of vegetables. The DM scooped up a four ounce scoop and agreed what was served was approximately two ounces. Review of the menu revealed garlic bread was to be served and was not. When the DM #13 was asked why the pureed diets were not served garlic bread he stated the pureed garlic bread had not come in on the truck. He was asked if he could have pureed the garlic bread in the kitchen, he stated they could have but admitted they did not. He cited the reason as being staffing. Continued observation revealed the residents were served ice cream instead of pureed pears per the menu and again he stated it didn't come in on the truck. All three pureed diets on the cart were served the smaller portions and no garlic bread affecting Residents #18, #42, and #94. This deficiency is cited as an incidental finding to Complaint Number OH 273.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, review of food temperature log, and staff interview, the facility failed to serve food that is at a safe and appetizing temperature. This had the potential to affect all residents on the designated COVID-19 halls (Residents #5, #8, #9, #10, #12, #14, #18, #20, #21, #22, #23, #26, #27, #28, #30, #33, #34, #35, #36, #37, #40, #41, #42, #46, #48, #54, #58, #60, #62, #63, #71, #74, #77, #78, #82, #90, #92, #94, #95, #97, #101, #103, #104, #105, #106, #108, #111, #112, #114, #116, #117). The faciity census was 118. Findings include: Observation on 06/11/20 at 12:00 P.M. revealed meals were being passed and delivered from an open cart with a large plastic bag covering the cart. The meals were on trays and food was in Styrofoam to go containers on the cart. A meal was removed, only one other tray had been served at that time, the dietary manager (DM) #13 took the temperatures of the food contained on the tray. The pureed lasagna was at 96 degrees Fahrenheit (F) and the vegetables were at 95 degrees. The dietary manager stated it should be warmer. He stated the food was at the proper temperature when it left the kitchen. Review of the food temperature log revealed the lasagna was at 168 degrees when the temperature was checked in the kitchen and the pureed vegetables were at 170 degrees. He stated he was unaware there was a problem with the food being cold. He also stated he had not tried anything to ensure the food was being served hot to the units since the food has to be brought from the West kitchen (in the West Building) to the East building. DM #13 verified they had not tried using hot plates or a heated cart to deliver the food. DM #13 stated they are bringing the carts from the other building while the kitchen in the East building is being repaired. He stated they were using the Styrofoam containers due to COVID-19. Interview with State tested Nurse Aide (STNA) #8 on 06/11/20 at 10:27 A.M. revealed the resident's food on the COVID-19 designated halls (located in the East building) have been cold when arriving to the unit. Interview on 06/11/20 at 2:10 P.M. with STNA #15 revealed she has had resident complaints of cold food. This deficiency substantiates Complaint Number OH 273.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **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 Nursing Home guidance from the Centers for Disease Control and Prevention (CDC), Ohio Department of Health (ODH) documents, Centers for Medicare and Medicaid Services (CMS), observation, interview and record review, the facility failed to ensure that policies and procedures designed to identify and mitigate infections with [DIAGNOSES REDACTED]-CoV-2 virus had been sufficiently developed in accordance with CDC and CMS recommendations; and failed to ensure that interventions to contain and prevent the spread of COVID-19 infections were consistently implemented. This affected 51 residents residing in the COVID-19 designated units, Halls B, C and D in the East building at the time of the survey (Residents #5, #8, #9, #10, #12, #14, #18, #20, #21, #22, #23, #26, #27, #28, #30, #33, #34, #35, #36, #37, #40, #41, #42, #46, #48, #54, #58, #60, #62, #63, #71, #74, #77, #78, #82, #90, #92, #94, #95, #97, #101, #103, #104, #105, #106, #108, #111, #112, #114, #116, #117) and the potential to affect all 118 residents residing in the facility. Findings include: Interview of the Administrator on 06/11/20 at 10:27 A.M., revealed there were three halls designated to COVID-19 positive residents in the East building (Halls B, C, and D). The facility currently had 51 positive residents after mass testing was completed on 06/05/20. There were eight residents prior to this testing who had tested positive beginning on 05/27/20. There have been 17 staff who tested positive for COVID-19 in total. She stated they have not tested all staff. The staff who tested positive received testing on their own. 1. Observation on 06/11/20 at 1:40 P.M. revealed a smoking patio located outside the dining room revealed three residents were outside smoking. They were observed to be sitting close together (not six feet apart). State tested Nursing Assistant(STNA) #1 was supervising the residents smoking. At the time of the observation, interview with the Administrator verified the residents were not sitting at least six feet apart. The Administrator then prompted STNA #1 to move the residents a safe distance from each other. 2. Observations on 06/11/20 at 12:00 P.M. revealed staff on B hall in the east building were passing meal trays. STNA #3 was passing trays wearing two pairs of gloves. At the time of the observation, interview with STNA #3 revealed she removes the outer gloves before coming out of the resident room and uses hand sanitizer to clean her inner gloves between rooms. The Licensed Practical Nurse (LPN) #2 was passing medications. She was observed to be wearing two pairs of gloves. She entered a resident room to administer medications. When she returned to the medication cart, she had on one pair of gloves and was observed to be cleaning her gloves with hand sanitizer. When questioned about this practice, she stated she wears double gloves before going into the room, removes the outer pair of gloves before exiting the room and uses hand sanitizer when she returns to her cart to clean her gloves. She stated she doesn't change the inner gloves unless they become soiled throughout the day, then she would change both. Interview on 06/11/20 at 1:00 P.M. with Regional Registered Nurse (RN) #4 revealed the facility had no policy to wear double gloves and those employees were doing that on their own. 3. Observation during tour of the B

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) hall (COVID positive) on 06/11/20 at 12:00 P.M. revealed resident room [ROOM NUMBER], 18, 19 and 20 did not have paper towels available in the rooms for staff or residents to perform hand hygiene. Observation of the medication room on 06/11/20 at 3:25 P.M. revealed no paper towels were available at the hand washing sink for hand hygiene. 4. Observation during tour of the COVID-19 designated units on 06/16/20 at 11:30 A.M. revealed the following: D hall- no trash liner was in room [ROOM NUMBER], no hand sanitizer on the medication cart, no paper towels in room [ROOM NUMBER] and room [ROOM NUMBER]. This hall had hand sanitizer at the nurse's station only which was outside the closed doors to the unit. B hall- trash barrel at the end of the hall for personal protective equipment (PPE) had no liner and PPE gowns and gloves were noted in the trash barrel. Random rooms were checked, and no paper towels were found in Rooms 26, 16, 23, and 21. room [ROOM NUMBER] had what appeared to be a melted popsicle on the bedside table that had ran onto the floor in a puddle and had no trash liner in the trash container. room [ROOM NUMBER] trash container contained clothing and trash and the liner was slid down inside. room [ROOM NUMBER] was noted with food on the floor, trash bag with trash and bag with laundry was on the floor in the bathroom. room [ROOM NUMBER] floor was sticky. room [ROOM NUMBER] floor was dirty. Two linen carts were observed in the hall by the exit door uncovered with items such as socks lying on the floor next to the cart. room [ROOM NUMBER] for a resident who was out of the facility at the time, revealed the room was dirty and cluttered. The room was covered with trash and other items thrown on the floor which included but not limited to, silverware, ice pitcher, dirty food containers, cords, trash, chip wrappers, razor and much more. There was a fuzzy type area rug that was matted, and matter stuck into the rug. The bed was piled with clothes and other items, closet was open with items spilling out as well as a wardrobe with the doors open and unable to be closed. The bathroom floor was dirty, chili cans sitting on top of the sink area with rotted dried food inside. On the sink was what appeared to be black and gold matter that was melted onto the sink. The shower room was observed cluttered with wheelchairs stored in the shower room, one blocking the shower stall and another one piled with Hoyer lifts pads that were spilling over onto the floor and trash barrels in the room. This hall had a hand sanitizer only at each end of the hall and on the nurse ' s cart. C hall- was observed to have only one available hand sanitizer on the wall for use and when exiting the unit, the hand sanitizer container was empty. The above observations were confirmed by the Director of Nursing (DON) at the time of the observations. The DON stated they don't put hand sanitizer in resident rooms. She also stated they didn't have enough hand sanitizer to put in all the resident rooms. 5. On 06/11/20 at 12:00 P.M. the Administrator was asked to provide any type of cleaning logs or evidence to ensure the rooms had been cleaned daily and that terminal cleaning was done when residents were moved to the East building (designated as the COVID positive units). This information was never provided to the surveyor. Interview on 06/11/20 at 10:27 A.M. with STNA #8 revealed the facility had been moving residents to the COVID-19 designated units without cleaning the rooms. She stated they don't have enough housekeeping staff, and this has been going on for months. Interview on 06/11/20 at 2:20 P.M. with LPN #10 revealed the housekeeping could be better; they don't have enough housekeepers. Interview on 06/11/20 at 2:25 P.M. with Housekeeper #11 revealed there were two housekeepers today. One in the West building and one in the East building, however, the one in the East building was sent to the West building to train. She stated she didn't know how many housekeepers they should have daily. She stated the East building was not cleaned. She stated she cleaned two halls in the West building (G and H) but E and F were not cleaned. Interview on 06/11/20 at 3:30 P.M. with two nursing staff, who wished to remain anonymous, revealed the facility did not have enough staff. These staff members reported they had no paper towels in any of the rooms or other areas, no housekeepers in the East building, no cleaning supplies for a week or no bleach wipes. They stated they did not have enough time to get their jobs done in a timely manner with all the isolation precautions needed and lack of supplies and housekeeping. Interview on 06/16/20 at 2:54 P.M. Housekeeper #12 revealed the East building should have two housekeepers and same in the West building. She stated they were limited now with staff. She stated they have been working short staffed and sometimes she will clean extra rooms. She stated when they are short of staff, she will have coworkers check the rooms for trash and see if the floors are okay. She stated the supervisor left about a month ago. She stated they do keep logs of rooms that need deep cleaned and they have one log with a two-hour cleaning schedule. She stated they have a sheet that has the rooms that need to be cleaned and room number. This log was not provided to the surveyor after request. Interview on 06/11/20 at 2:40 P.M. with the Administrator revealed the housekeeping department had staff off work due to COVID-19, they didn't want to work. At this time, the Administrator provided the surveyor with the Facility Assessment (dated 05/18/20). According to the assessment, the facility requires two housekeepers in each building, East and West. When reviewing the time sheets the Administrator provided, she agreed they did not have two housekeeping staff per building. The time sheets revealed there were only three of 15 days reviewed when the facility had the required number of housekeeping staff. Interview on 06/16/20 at 1:50 P.M. with the Administrator revealed the housekeeping director left employment and she was in charge until the new housekeeping director started on 06/16/20. The Administrator was not able to provide evidence she or someone else had supervised and inspected the units periodically to ensure supplies were available and cleaning was completed. Review of Ohio Department of Health document titled, Key Points for COVID-19 in Long Term Care Setting provided by the facility revealed, to keep COVID-19 from entering and spreading in your facility, all facilities should strengthen hand hygiene adherence. Place alcohol-based hand rub in every resident room to facilitate hand hygiene by staff. Keep sinks stocked with soap and water and paper towels. Review of CMS policy memo QSO-20-14-NH revised 03/13/20 titled, Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes, revealed facilities were to Increase the availability and accessibility of alcohol-based hand rubs, reinforce strong hand-hygiene practices Ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms. Review of the Ohio Department of Health documented titled, Guidelines for cleaning and disinfection for [DIAGNOSES REDACTED]-CoV-2, Best Practices for Long-Term-Care Facilities include: establish written cleaning/disinfection policies which include routine and terminal cleaning of resident rooms, cleaning when contact/droplet precautions are in place, high-touch surfaces and common areas. Cleaning activities should be supervised and inspected periodically to ensure correct procedures. Room cleaning: daily cleaning and high touch surfaces every shift (door handles, bedside tables, bed rails, television remote, call button and light switches). Review of the Center for Disease Control (CDC) document titled, Strategies for Optimizing the Supply of Disposable Medical Gloves revealed the CDC does not recommend double gloves when providing care to suspected or confirmed COVID-19 patients. Review of the CDC directive titled, Interim Infection Prevention and Control Recommendations for Patients with suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings dated 4/13/20, revealed the following guidance regarding, healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location. The same policy further directs that staff are to Put on clean, non-sterile gloves upon entry into the patient room or care area Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene. This deficiency substantiates Complaint Number OH 273.