STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365065	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARRISON PAVILION CARE CENTER	2171 HARRISON AVENUE CINCINNATI, OH 45211

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 -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to appropriately screen transport personnel for signs and symptoms of Coronavirus Disease 2019 (COVID 19). Additionally, the facility also failed to properly dispose of trash collected from an isolation room. This had the potential to affect all 74 residents residing in the facility. Facility census was 74. Findings include: 1. Review of Resident #1's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for Resident #1 dated 04/06/20 revealed resident was cognitively impaired and required limited assistance with activities of daily living. Observation on 06/25/20 at 9:46 A.M. of Driver #400 revealed the driver was standing outside the transport van in the parking lot near the facility entrance with the back doors open and the chair lift positioned for resident use. Driver #400 was not wearing a mask. Observation on 06/25/20 at 9:50 A.M. revealed Driver #400 propelled Resident #1 in his wheelchair, placed resident on chair lift and into the van, and closed the back doors of the van. Observation revealed Resident #1 was wearing a surgical mask covering his nose, mouth, and chin, and Driver #400 was not wearing a mask while propelling Resident #1 to the van and assisting him into the vehicle. Further observation revealed Driver #400 retrieved a mask from the passenger side of the vehicle and donned it after he had assisted resident into the van upon being asked by the surveyor regarding whether he had a mask. Interview on 06/025/20 at 9:51 A.M. with Driver #400 revealed the driver did not verbally respond to surveyor's question regarding whether he had a mask available. Interview on 06/25/20 at 1:15 P.M. with Hospitality Aide #100 confirmed she did not screen Driver #400 for signs and symptoms of COVID 19 and she did not observe whether he was wearing a mask when he picked up Resident #1 to transport him to his [MEDICAL TREATMENT] appointment. Interview on 06/25/20 at 1:20 P.M. with State tested Nursing Assistant (STNA) #200 confirmed she wheeled Resident #1 to the door on 06/25/20 at approximately 9:50 A.M. so a transport service could take him to his [MEDICAL TREATMENT] appointment. STNA #200 confirmed Resident #1 was wearing a mask when she wheeled him out to the transport van, but Driver #400 was not wearing a mask. STNA #200 confirmed she asked the driver if he had a mask, but he did not answer her question, nor did he don a mask. STNA #200 confirmed she then left Resident #1 in Driver #400's care and went back inside the facility. Interview on 06/25/20 at 1:25 P.M. with the Administrator confirmed the facility did not screen Driver #400 for signs and symptoms of COVID 19 and the facility practice was not to screen drivers because they do not enter the facility. Administrator further confirmed facility practice for residents going out to medical appointments is for staff to assist residents outside the building and the drivers assist residents into the transport vehicles. Review of the facility screening log for all visitors and outside vendors dated 06/25/20 revealed Driver #400 was not screened prior to allowing him to wheel Resident #1 to the transport vehicle and assist resident into the vehicle using an electric chair lift. Review of facility policy titled COVID 19 dated 05/11/20 revealed the facility would restrict or limit visitation and/or entry to the facility for reasonable and clinical safety reasons, and the facility would actively screen all visitors, staff, volunteers and vendors for signs and symptoms of respiratory infection, possible contact with an individual with a confirmed [DIAGNOSES REDACTED]. Review of facility policy titled Infection Control Measures During Pandemic dated April 2011 revealed the facility would train staff to visually and verbally screen visitors at facility entry points for respiratory symptoms of [MEDICAL CONDITION] 2. Review of record for Resident #4 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED]. Review of the MDS for Resident #4 dated 04/13/20 revealed resident was cognitively impaired and required supervision with ADLs. Review of record for Resident #5 revealed an admission date of [DATE] with a [DIAGNOSES REDACTED].#5 revealed resident was cognitively impaired and required extensive assistance of one staff with ADLs. Observation on 06/25/20 at 10:10 A.M. revealed Residents #4 and #5 shared a room and there was a sign on the door indicating the residents were on droplet precautions. Further observation revealed two bags of trash were sitting on the floor outside of the Resident #4 and #5's room. Interview with the Administrator on 06/25/20 at 10:05 A.M. confirmed the facility had placed all residents in the facility on droplet precautions due recent positive confirmed cases of COVID 19 occurring within the facility. Interview on 06/25/20 at 10:10 A.M. with Housekeeper #500 confirmed she had removed the trash from Resident #4 and #5's room and she had placed them on the floor outside the residents' room. Housekeeper #500 further confirmed trash should not be placed on the floor but should have been placed in a covered garbage can. Interview on 06/25/20 at 10:20 A.M. with Licensed Practical Nurse (LPN) #300 confirmed trash should not be placed on the floor but should be taken directly to a covered garbage can in the hall. Review of facility policy titled Infection Control Measures During Pandemic dated April 2011 revealed if an outbreak of pandemic occurs within the facility strict adherence to standard and transmission-based precautions and infection control measures will be implemented.

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