STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366389	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOREST HILLS CARE CENTER	8700 MORAN ROAD CINCINNATI, OH 45244

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 medical record review, observation, interview, review of information from Centers of Disease (CDC) and facility policy review the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) when caring for new admissions to prevent the spread of the coronavirus (COVID 19). This affected two Residents (#24 and #100) out of two resident reviewed for new admissions. The facility identified 31 residents who were admitted to the facility in the last 30 days. None of the current residents had COVID 19. The facility census was 63. Findings include: 1. Review of closed medical record review revealed Resident #100 was admitted to the facility on [DATE] with the following diagnoses; unspecified fracture of upper end of right humerus, [DIAGNOSES REDACTED], essential hypertension, [MEDICAL CONDITION], weakness and [MEDICAL CONDITION]. The resident was sent to the hospital on [DATE]. Review of Resident #100's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderate cognitive impairment and was reported to require extensive assistance with transfers, bed mobility, dressing and toileting. Resident #100 was also independent with eating and required supervision with personal hygiene. Review of Resident #100's temperatures from 07/13/20 to 07/30/20 revealed the resident had an elevated temperature on 07/22/20 of 100.4 degrees Fahrenheit (F) and on 07/23/20 his temperature was 101.6 degrees F. Review of Resident #100's progress notes revealed the nurse practitioner was in the facility to see the resident on 07/22/20 and no new orders were given. Further review of Resident #100's progress notes revealed on 07/23/20 the resident had a temperature of 101.6 degrees F and was noted with increased confusion. Resident #100's physician was contacted and a new order was received for urinalysis culture and sensitivity (UA C&S) and Tylenol 650 milligrams (mg) by mouth every six hours as needed. Review of progress note dated 07/30/20 revealed Resident #100 had an episode of emesis and diarrhea and was visually shaking. Partial lab results were received, the the physician was updated on the residents condition and of the partial lab results. The physician ordered an antibiotic and further labwork. On 07/30/20, Resident #100 was sent out to the emergency room due to his oxygen saturation dropping. The facility notified the county health department that Resident #100 had tested positive for COVID 19. Interview with the Director of Nursing (DON) on 08/12/20 at 11:24 A.M. revealed Resident #100 was originally admitted to the 100 hallway prior to them admitting new residents to the 400 hallway. The DON verified Resident #100 resided on the 100 hallway with residents that had been at the facility for over 14 days. 2. Record review revealed Resident #24 was admitted to the facility on [DATE] with the following diagnoses; overactive bladder, essential hypertension, [MEDICAL CONDITION] and atopic [MEDICAL CONDITION]. Resident #24's Minimum Data Sets (MDS) assessment had not been completed. Review of Resident 24's admission assessment and baseline care plan dated 08/08/20 revealed the resident was alert and oriented to person, place, time and situation. Resident #24 also required extensive assistance with bed mobility, dressing and personal hygiene. Resident #24 required limited assistance with eating. Observation of the facility's 400 unit during the initial tour of the facility on 08/12/20 at 9:24 A.M. revealed no signage on the resident doors or in the hallway to indicate any of the residents were on precautions or what type of personal protective equipment (PPE) should be worn while providing care to the residents. There was no PPE noted inside or outside of any of the rooms on the 400 unit. The residents on the 400 unit were observed in private rooms and their doors were shut. During the initial tour the Director of Nursing (DON) was interviewed and revealed all newly admitted residents from the hospital resided on the 400 unit in private rooms. The DON verified there was no signage on any of the resident doors on the 400 hallway to indicate that the residents were newly admitted or on precautions. The DON also verified that there was no PPE located inside or outside of any of the resident rooms on the 400 hallway. The DON stated all staff in the facility wore a KN95 mask but did not use any additional PPE when caring for newly admitted residents due to the facility requiring one negative COVID 19 test prior to admission. The DON also verified the 400 unit housed new admissions and residents who were admitted over 14 days. There was no designation to indicate which residents were new admissions or who was under observation for COVID 19. The DON also confirmed that the facility did not use designated staff to care for newly admitted residents during their 14 day observation period on the 400 hallway. Observation of State tested Nurse Aide (STNA) #1 and STNA #2 on 08/12/20 at 10:30 A.M. revealed STNA #1 going in and out of several resident rooms on the 400 unit caring for residents while only performing hand hygiene and wearing a KN95 mask. Interview with STNA #1 at the time of the observation verified that there were no signs or PPE carts on the 400 unit to designate which residents were new admissions. STNA #1 stated she only wore a KN95 mask and gloves when caring for all the residents on the 400 unit including new admissions. STNA #1 reported during report she was told which residents were new admissions and she could also look it up on the computer. STNA#1 also stated the staff did not use any additional precautions with new admissions because the residents had to have a negative COVID 19 test prior to admission. STNA #1 verified the 400 unit housed both new admissions and residents who were admitted over 14 days. Telephone interview on 08/12/20 at 1:47 P.M. with Local Health Department #300 revealed new admissions to the facility should ideally be separated from other residents and appropriate PPE should be used with new admissions. Review of the facility's undated Protocol for Admission/Readmission Quarantine Hall policy revealed the facility will adhere to the CDC infection control guidelines to prevent the spread of COVID 19 while maintaining the recommended level of social interaction. Further review of the policy revealed residents who are admitted or readmitted after non-COVID-related illnesses whose COVID-19 status is not known will be placed in transmission based precautions on a separate observation unit or a single person room until 14 days have elapsed since the time of admission or re-admission and they remain asymptomatic. Review of a CDC article entitled Responding to COVID 19 in Nursing Homes (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) dated 04/20/20 revealed the facility should create a plan for managing new admissions and readmissions whose COVID 19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID 19. The article also revealed all recommended COVID 19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator, eye protection, gloves, and gown. Further review of the article revealed a single negative test upon admission did not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID 19 for 14 days after admission and cared for using all recommended COVID 19 PPE.

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.