STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366399	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COVENANT VILLAGE OF GREEN TOWNSHIP	**3210 WEST FORK ROAD 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 -** Some	**Provide and implement an infection prevention and control program.** Based on observations, staff interview, review of the facility policy and Review of the Centers for Disease Control and Prevention (CDC) website, the facility failed to appropriately handle clean linen to prevent the spread of Coronavirus Disease 2019 (COVID-19). This had the potential to affect 40 (#38, #39, #40, #41, #42, #43, #44, #45, #46, #47, #48, #49, #50, #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77) residents residing on the isolation unit In addition, the facility failed to appropriately dispose of trash on the quarantine unit to prevent the spread of infection which had the potential to affect 14 (#23, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37) residents residing on the quarantine unit. The total facility census was 77. Findings include: 1. Observation on 07/08/20 at 8:00 A.M., revealed the facility designated Rooms #201 through #250, as an enclosed isolation unit. The doors to the unit were closed with signage indicating the entire resident population of the unit was on droplet precautions. Observation on 07/08/20 at 8:10 A.M., revealed an employee wheeled a cart of cloth isolation gowns through the closed doors of the facility-identified isolation unit. The mesh covering of the cart was pulled to the top of the cart exposing the clean gowns; and clean bath blankets were stacked on top of the cart. Interview on 07/08/20 at 8:00 A.M. with the Administrator, confirmed the facility designated Rooms #201 through #250, as an enclosed isolation unit with every resident placed on droplet precautions due to possible exposure to COVID-19. Interview on 07/08/20 at 8:11 A.M. with Laundry Worker #100, confirmed she had wheeled the cart containing the cloth isolation gowns and bath blankets on top, from the laundry room downstairs, up the elevator, through the rotunda, near the front lobby, and through the closed doors of the isolation unit. Laundry Worker #100 further confirmed the front covering of the linen cart was pulled up exposing the isolation gowns and bath blankets, and the cart had been transported from the laundry room in this manner. Interview on 07/08/20 at 11:39 A.M. with Environmental Services Director #120, verified the laundry cart should always be covered during transport except when removing items. Review of the facility policy titled, General Infection Control, dated 03/09/20, revealed clean linens would be transported in a manner that ensured cleanliness and protection during transport. Review of the Centers for Disease Control and Prevention (CDC) website (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html), per CDC information and guidelines titled, Guidelines for Environmental Infection Control in Health-Care Facilities, edited 2017,(https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html#g), revealed the facility should package, transport, and store clean textiles and fabrics by methods that would ensure their cleanliness and protect them from dust and soil during interfacility loading, transport, and unloading. 2. Observation on 07/08/20 at 8:25 A.M., revealed a large bag of trash was sitting on the floor near the nurses' station on the facility identified quarantine unit. Interview on 07/08/20 at 8:20 A.M. with the Administrator, verified the facility designated Rooms #123 and #125 through #152, as an enclosed quarantine unit for residents newly admitted or readmitted . Interview on 07/08/20 at 8:26 A.M. with Housekeeper #105, confirmed she had pulled the large bag of trash from the nurses' station and the ice room on the quarantine unit and had placed the trash on the floor adjacent to the nurses' station. Housekeeper #105 indicated she planned to take the trash to the dumpster which was located outside of the quarantine unit and through the employee entrance. Review of the facility policy titled, General Infection Control, dated 03/09/20, revealed the facility would ensure a safe and sanitary environment to control and prevent the transmission of infections and diseases.

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.