

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 365636	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2020
NAME OF PROVIDER OF SUPPLIER PICKERINGTON CARE AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 1300 HILL ROAD NORTH PICKERINGTON, OH 43147	
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 F 0880	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
<p>Level of harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, medical record review, staff interview, and facility policy review, the facility failed to follow proper policies and procedures regarding isolation precautions. This had the possibility to affect 69 of 69 residents. Also, the facility failed to dispose of infectious materials in an appropriate manner. This had the potential to affect 69 of 69 residents. Finally, the facility failed to use gloves at all required times. This had the potential to affect 26 (Residents #1, #2, #3, #4, #5, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, and #29) of 26 residents who were in isolation. The facility census was 69. Findings include: 1. Observation on 06/11/20 at approximately 7:30 A.M. and 7:37 A.M. revealed the facility had two coronavirus units. Each unit had a plastic curtain that blocked it off from the rest of the facility. There were no signs on the outside of each unit that indicated the entire units were under isolation precautions. Also, there were no signs outside of each resident's door to indicate who/which rooms were on isolation precautions. There was not personal protective equipment (PPE) storage units outside each of the doorways to indicate which rooms were on isolation precautions. Since the whole unit was designated as being on isolation precautions, PPE storage units were not required to be outside every door, but there was no indication on each unit which rooms (or the entire unit) was on isolation precautions. Review of facility medical documentation revealed the following residents were on the coronavirus units due to having positive coronavirus tests: Residents #1, #2, #3, #4, #5, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, and #29. Interview with Director of Nursing (DON) on 06/11/20 at 7:45 A.M. and Administrator on 06/11/20 at 2:30 P.M. confirmed both coronavirus units did not have signage to indicate that all rooms inside those units were on isolation precautions. They confirmed there should have been notifications that anyone going into the units needed to wear PPE and/or speak with a nurse prior to entering. Review of Care for the Patient with Suspected or Confirmed Coronavirus 2019 policy (dated 05/06/20) revealed, patients with known or suspected COVID-19 should be cared for in a single person room with the door closed and a private bathroom or bedside commode. A sign will be placed on the door and PPE equipment will be placed outside the resident's room. 2. Review of facility medical documentation revealed the following residents were on the coronavirus units due to having positive coronavirus tests: Residents #1, #2, #3, #4, #5, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, and #29. Interview with Housekeeping Staff #104 on 06/11/20 at 8:15 A.M. revealed when she had to take the trash out of the coronavirus units, she took the trash bags (some red biohazard and some clear/regular trash bags) placed the bags in a circular trash can and wheeled the trash can out to the dumpster. All trash bags (red and clear) were placed in the same dumpster. She stated when she took the trash can out to the dumpster, she took a gown and gloves out with her, put them both on while dumping the contents of the trash can into the dumpster, and then threw the gown and gloves (loose) into the dumpster as well. She confirmed the gown and gloves that she used when dumping the trash can into the dumpster was not placed into a bag before being thrown into the dumpster. 3. Observation on 06/11/20 at approximately 7:53 A.M. revealed State tested Nursing Aide (STNA) #105 was in a resident's room in one of the coronavirus units without gloves. While she was in the room, she was picking up the floor mat beside the resident's bed without having gloves on her hands. This was confirmed by the DON at the time of the incident. Additionally, observation on 06/11/20 at approximately 8:20 A.M. revealed STNA #101 and STNA #102 in the other coronavirus unit, going in and out of multiple resident rooms without gloves. When they went in the resident's room, they came out with their finished breakfast trays and put them on the meal cart. They did not use gloves when they went in to pick up the trays and did not wash their hands after each tray was picked up. Review of facility medical documentation revealed the following residents were on the coronavirus units due to having positive coronavirus tests: Residents #1, #2, #3, #4, #5, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, and #29. Interview with STNA #101 and STNA #102 on 06/11/20 at 8:25 A.M. confirmed they did not have to wear gloves when they went into a resident's room (on the coronavirus unit) if they did not provide resident care. They confirmed they went into multiple residents' rooms without gloves to get their breakfast trays, and brought them back out to the hallway and placed them on the meal cart. They confirmed that the residents each ate their breakfast and more than likely touched the tray as well. They confirmed they did not wash their hands or use hand sanitizer after picking up the trays as well. Review of Care for the Patient with Suspected or Confirmed Coronavirus 2019 policy (dated 05/06/20) revealed, facility staff who enter the room of a patient known or suspected COVID-19 should adhere to standard precautions and use a respirator or facemask, gown, gloves, and eye protection. Also, the policy stated, put on clean, non-sterile gloves upon entry into the patient room or care area.</p>		
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.