STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366428	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
O'NEILL HEALTHCARE FAIRVIEW PARK	20770 LORAIN ROAD FAIRVIEW PARK, OH 44126

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 observation, interview and record review, the facility failed to properly prevent and or contain the spread of covid-19. This affected 37, Residents #203, #204, #205, #209, #210, #211, #212, #213, #214, #215, #216, #217, #218, #219, #220, #221, #222, #223, #224, #225, #226, #227, #228, #229, #230, #231, #232, #233, #234, #235, #236, #237, #238, #239, #240, #241, and #242, of 40 residents (Residents #206, #207, and #208) diagnosed with [REDACTED]. This affected two laundry staff, Housekeeping Supervisor #112 and Housekeeper #111 and had the potential to affect all residents. The total census was 68. Findings include: 1. Record review on 06/29/20 revealed three Residents, (Resident #206, #207 and #208) had been diagnosed with [REDACTED]. Record review revealed an additional six residents, Residents #209, #210, #211, #212, #213, and #214, were diagnosed with [REDACTED]. Record review revealed an additional 31 residents were diagnosed with [REDACTED].#203, #204, #205 #215, #216, #217, #218, #219, #220, #221, #222, #223, #224, #225, #226, #227, #228, #229, #230, #231, #232, #233, #234, #235, #236, #237, #238, #239, #240, #241, and #242), between the dates of 06/20/20 through 06/23/20. Record review on 06/29/20 revealed six staff members, State tested Nursing Assistant (STNA) #104, STNA #106, STNA #115, Laundry assistant #116, Licensed Practical Nurse (LPN) #117, and STNA #114, were diagnosed with [REDACTED]. Staffing record review revealed five of the six staff members diagnosed with [REDACTED].#104, STNA #106, STNA #115, Laundry assistant #116 and STNA #114, had routine staff assignments on the south side of the facility. Interview with the Director of Nursing (DON) on 06/29/20 at 9:00 AM revealed all 40 residents resided on the south side of the facility when diagnosed with [REDACTED].#117 worked both north and south of the facility. Review of the facility layout revealed the south side of the facility had two halls which included two person rooms. Room numbers for the south side of the facility were rooms one through 35. The 40 residents that were diagnosed with [REDACTED]. Interview with the DON on 06/29/20 at 9:00 AM revealed on 05/17/20 Residents with a [DIAGNOSES REDACTED].#206 and #207, were transferred to the north side of the facility (which also had two halls) where an isolation unit was implemented at the farther end of one hall. Additional residents (which all resided on the south side) were transferred to the unit (on the north side) as they were diagnosed with [REDACTED]. On 06/23/20 a second covid-19 isolation unit was implemented on the south side of the facility due to the number of residents infected. Interview on 06/30/20 at 12:45 P.M. with the DON and Staff Coordinator #118 revealed the south side of the facility had been broken down to four to five assignments each day, each shift depending on the amount of staff available. Each STNA had been given an assignment by the charge nurse at the beginning of the shift. Record review of the STNAs #104, #106, #114, and #115's schedule and daily assignment sheet during the period of 06/01/20 through 06/22/20, when the last STNA that was diagnosed with [REDACTED]. Interview with the DON on 06/29/20 at 2:15 P.M. revealed the two nurses per shift on the south side worked together on the hall assignments and had no consistent assignment. The DON confirmed no residents had been admitted with covid-19, all residents acquired covid-19 while at the facility. Guidance from the CDC revealed - Long-term care facilities should exercise as best as possible consistent assignment (meaning the assignment of staff to certain patients and residents) for all patients and residents regardless of symptoms or COVID-19 status. Interview on 06/29/20 at 6:23 P.M. with STNA #103 revealed she had routinely worked with residents infected with covid #19 and on the same shift worked with residents who are not infected to cover breaks. Interview with LPN #107 on 06/29/20 at 6:35 P.M. revealed she had also routinely worked with residents on the same day who were infected and who were not infected with covid-19. Interview with LPN # 109 and Registered Nurse (RN) #110 on 06/30/20 between 8:45 A.M. and 8:55 A.M. revealed they had also routinely worked with residents on the same day who were infected and who were not infected with covid-19. Interview on 06/30/20 at 9:30 A.M. with the DON confirmed nurses work daily on all shifts with both covid-19 positive and non covid-19 positive residents. The DON stated, It would not be fair to give more residents to one nurse than the other. 2. Observation on 06/30/20 at 8:55 A.M. revealed Housekeeper #111 transporting a metal laundry cart which had crisscross metal wires, no lid, and no label and contained soiled laundry from the south covid-19 isolation unit. Housekeeper #111 transported the open cart to the laundry area located at the lower level of the facility. Observation on 06/30/20 at 9:00 A.M. revealed Laundry Supervisor #112 took the laundry from the cart and placed it into the washing machine. Laundry Supervisor #112 then removed her gloves, then the apron and walked over to the folding table in the next room and began folding towels. Observation was confirmed with Laundry Supervisor #112 and housekeeper #111 that Laundry Supervisor #112 did not wash her hands, did not use hand sanitizer after placing the soiled clothing from the covid-19 unit into the washer and before folding clean facility use towels. Review of the facility laundry guidelines did not include washing hands or using hand sanitizer after contamination with soiled laundry. The facility guidelines did have a policy which included that soiled laundry will be transported in a leak proof covered container that is labeled. 06/30/30 at 3:30 P.M. with the Administrator revealed she would had expected everyone to wash their hands after removing gloves.

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