STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366198	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN YEARS NURSING CENTER	2436 OLD OXFORD ROAD HAMILTON, OH 45013

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, staff interview, review of facility infection control policies and procedures, and review of an article from Centers for Disease Control (CDC) the facility failed to implement procedures regarding hand hygiene and isolation precautions in order to prevent the potential spread of the coronavirus (COVID-19). This directly affected four Residents (#3, #4, #6 and #32) of six reviewed and had the potential to affect 18 other Residents (#1 - #3, #5, #7 - #18, #30, and #31) who resided on the 200 and 400 wings at the facility. The facility had an outbreak of COVID and were in the process of transferring the COVID positive residents to a different facility. The facility census was 38. Findings include: 1. Record review revealed Resident #4 was originally admitted to the facility on [DATE] with the following diagnoses; hypertensive [MEDICAL CONDITION] with heart failure, [MEDICAL CONDITION], muscle weakness, cognitive communication deficit, muscle wasting and atrophy, irritable bowel syndrome, heartburn and generalized anxiety disorder. Resident #4 was readmitted to the facility on [DATE] after being admitted to the hospital for altered mental status. Review of Resident #4's quarterly Minimum Data Sets (MDS) assessment dated [DATE] revealed the resident had moderate cognitive impairment and required supervision with with bed mobility, transfers, toileting and dressing. Resident #4 was independent with personal hygiene and eating. Review of Resident #4's orders revealed Resident #4 was ordered droplet precautions from 09/16/20 to 09/30/20 due a recent hospital visit. 2. Record review revealed Resident #6 was admitted to the facility on [DATE] with the following diagnoses;[MEDICAL CONDITIONS] of right lower limb, type two diabetes mellitus, muscle weakness, dysphagia, unsteadiness on feet, other symbolic dysfunctions, acute kidney failure and osteo[DIAGNOSES REDACTED] Review of Resident #6's quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact and require extensive assistance with transfers, bed mobility, dressing and toileting. Resident #6 also required supervision with eating and personal hygiene. Review of Resident #6's orders revealed no orders for precautions. 3. Record review revealed Resident #3 was admitted to the facility on [DATE] with the following diagnoses; hypertension, dementia, anxiety and depression. Review of Resident #3's MDS assessment dated [DATE] revealed the resident was severely cognitively impaired. Observation of Resident #4's bedroom door on 09/16/20 at 12:06 P.M. revealed a notice to please report to nurse before entering, and a sign that indicated droplet precautions with an explanation of what personal protective equipment (PPE) to put on before entering the room to provide care or services. The sign indicated that the following PPE was to be worn into the room: gown, mask, goggles, and goggles/face shield. There was no isolation cart containing PPE outside the residents room. At the same time, State tested Nurse Aide (STNA) #50 walked into Resident #4's room to deliver a meal tray wearing only a mask and a gown. STNA #50 delivered and set up the meal tray, sanitized her hands, then took another meal tray out and went into Resident #3's room wearing the same gown. Resident #3 did not have any precautionary signs on his door. On 09/16/20, at 12:14 P.M., after serving Resident #4 and Resident #3, STNA #50 sanitized her hands, removed a tray from the tray cart and took the meal tray into Resident #6's room. Resident #6 also had signs on his door to please report to the nurse before entering, and a sign specifying the resident was on droplet precautions with an explanation of what PPE to put on before entering the room to provide care or services. There was an isolation cart outside his door. STNA #50 did not change her gown after being in Resident #4's room, who was on isolation, or Resident #3's room, before walking into Resident #6's room. She did not don a fresh gown, or gloves, but was wearing eye protection (goggles). STNA #50 when exited Resident #6's room, she was questioned as to what PPE she was supposed to wear into the room, and confirmed at that time she did wear the same gown that she had worn into the two previous rooms, and was not wearing gloves. She reported that she thought gloves were only necessary when providing hands on care to residents. 4. Record review revealed Resident #32 was admitted to the facility on [DATE] with the following diagnoses; [MEDICAL CONDITIONS] and [MEDICAL CONDITION] following cerebral infarction affecting left non dominant side, muscle wasting and atrophy, abnormal posture, other reduced mobility, dementia in other diseases classified elsewhere with behavioral disturbance, vitamin D deficiency, constipation and major [MEDICAL CONDITION]. Review of Resident #32's quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact and required extensive assistance with bed mobility, dressing, toileting and personal hygiene. Resident #32 also required total dependence with transfers, supervision with eating, Review of Resident #32's orders revealed no orders for precautions. On 09/16/20 at 12:25 P.M. STNA #58 was observed getting ready to enter Resident #32's room. She stated she was going into the room to see/assist in pulling the resident up in bed. She removed a gown and a surgical mask from the isolation cart outside the resident's room, and placed the surgical mask over her N95 mask STNA #58 then took her surgical mask off, and opened the biohazard trash container and lid outside the resident's room with her bare hands stating she needed gloves. Without washing or sanitizing her hands, after handling the biohazard trash can, she went to the nurses cart to get gloves and put them on, then got a surgical mask and placed over her N95 mask. At that time, STNA #58 was asked to verify that she had failed to wash her hands after handling the biohazard trash can and lid, and before donning a clean pair of gloves. STNA #58 affirmed she did not wash her hands prior to donning the clean gloves, and after handling the biohazard trash container. An interview was conducted with the Director of Nursing (DON) on 09/16/20 at 12:45 P.M. The aforementioned observations were shared with the DON at which time she confirmed there should have been an isolation cart outside Resident #4's room, that STNA #50 should have donned a fresh gown and gloves when entering Resident #4 and 6's rooms and removed them afterwards, and STNA #58 should have washed or sanitized her hands prior to getting clean gloves and donning them after handling the soiled biohazard trash container. Review of the facility's donning and doffing PPE for COVID-19 policy dated 04/14/20 revealed health care personnel should perform hand hygiene before and after all patient contact, contact with potentially infectious material and before putting on and after removing PPE including gloves. Review of CDC and Preventions article Using PPE dated 08/19/20 revealed gloves and gown are to be doffed prior to exiting the patients room.

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.