STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365309	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRIENDSHIP VILLAGE	**5790 DENLINGER ROAD DAYTON, OH 45426**

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 observations, staff interviews, review of staffing schedules, review of facility policy and review of the facility policy for Centers for Disease Control (CDC) staffing guidelines, the facility failed to ensure there was dedicated nursing staff working solely on the COVID-19 unit 1 (Rehab hall). This had the potential to affect 18 residents (#20, #21, #22, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, and #37) of 18 residing on the non-isolated West hall. The total facility census was 73. Findings include: Review of the licensed nursing staff schedules dated 06/22/20 revealed State tested Nurse Aide, (STNA) #222 was assigned to the West hall, non-isolated unit for the 6:00 A.M. to 3:00 P.M. shift. Interview on 06/22/20 at 2:47 P.M., with Registered Nurse (RN) #100, unit manager, revealed there was two aides scheduled on the COVID unit 1 for the 6:00 A.M. to 6:00 P.M. shift. Per RN #100, STNA #222 was working the COVID unit and was not scheduled to work on any other unit. RN #100 stated one aide had gone home prior to 3:00 P.M. and STNA #200, the aide scheduler, was asking other aides to be floated to the unit to cover the unit. RN #100 stated there was two other aides working the COVID unit 2 and they floated to COVID unit 1 if needed. RN #100 stated usual staffing scheduled two aides per COVID unit. Observation on 06/22/20 at 3:10 P.M., on the COVID unit 1 revealed STNA #222 was wearing appropriate Personal Protective Equipment (PPE) and answering call lights on COVID unit 1. STNA #222 answered the call light for room [ROOM NUMBER] at 3:10 P.M. and room [ROOM NUMBER] at 3:15 P.M. Interview on 06/22/20 at 3:15 P.M., with STNA #222 revealed the aide was screened prior to coming into work. STNA #222 stated she was working on the West Unit before being pulled to the COVID unit 1. STNA #222 stated she has been tested and was negative and had no signs or symptoms of [MEDICAL CONDITION]. STNA #222 stated once she was pulled to the COVID unit 1 she was told she was not to be working on the other non-isolated units. Interview on 06/22/20 at 3:27 P.M., with RN #111 revealed she was the nurse for COVID unit 1 and COVID unit 2. Per RN #111 the only aide on COVID unit 1 was STNA #222, who was pulled from another unit when one of the other aides went home early for non-virus reasons. Observation on 06/22/20 at 3:33 P.M., of the West Unit, revealed STNA #222 walking into residents' room answering call lights. Interview on 06/22/20 at 3:35 P.M., with STNA #222, in the presence of the Director of Nursing (DON) and the Administrator, revealed STNA #222 was scheduled to work the non-isolated West Unit and was not supposed to be working in the isolated COVID unit on 06/22/20. STNA #222 verified she was pulled to work the COVID unit 1 and then was told to return to her West Unit assignment. Interview on 06/22/20 at 3:40 P.M., with RN #100, RN #111, STNA #200, DON, and the Administrator revealed RN #100 and RN #111 both stated STNA #222 was working the COVID unit 1. The DON, STNA #200 and Administrator denied the fact STNA #222 was supposed to be working the COVID unit 1 and stated the aide was now back working in the non-isolated West Unit. Interview on 06/22/20 at 4:00 P.M., with the DON and the Administrator verified the facility's policy is to have designated staff work the COVID isolated units. Review of the facility's policy titled, COVID-19 Infection Control Policy , dated 03/11/20 revealed the facility will ensure only essential personnel will care for residents who test positive for [MEDICAL CONDITION] with designated staffing assignments. Review of the Centers for Disease Control and Prevention (CDC) websites (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html) updated 04/15/20, revealed per CDC information and guidelines: Given the high risk of spread once COVID-19 enters a nursing home, facilities must take immediate action to prevent residents, families and healthcare personnel (HCP) from severe infections, hospitalization s and death .Dedicate Space in the Facility to monitor and Care for Residents with COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Assign dedicated HCP to work only in this area of the facility. This citation substantiated Complaint Number OH 491.

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.