STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365578	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKLD NEW LEXINGTON ILLUMINATE HC NEW LEXINGTON	920 SOUTH MAIN STREET NEW LEXINGTON, OH 43764

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 the unprecedented coronavirus global pandemic that resulted in the Presidential declaration of a State of National Emergency declared 03/13/20, the Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) Memo QSO-20-14-NH (revised 03/13/20), Nursing Home guidance from the Centers for Disease Control and Prevention (CDC), observation, and interview, the facility failed to ensure staff wore appropriate personal protective equipment and followed standards of practice related to hand hygiene to contain and prevent the spread of COVID-19 infections. This had the potential to affect 17 residents on the COVID-19 unit (Residents #1, #3, #5, #11, #17, #21, #24, #26, #27, #30, #31, #35, #42, #47, #51, #63, and #66). Facility census was 65. Findings include: Interview on 07/29/20 at 3:05 P.M. with the infection control registered nurse (RN) #1 revealed there were four COVID-19 positive residents residing in the facility and one in the hospital. They had one staff test positive in April and one test positive in June and these staff had since returned to work. Another staff tested positive on 07/27/20 and remained off work. RN #1 said they tested all residents today, 07/29/20. Observations on 07/30/20 at 12:30 P.M. revealed Licensed Practical Nurse (LPN) #2 working on the COVID-19 unit. There were four residents with COVID-19 [DIAGNOSES REDACTED]. LPN #2 said she was the nurse for the unit and was responsible to meet all the residents' needs which included primary care, housekeeping and passing meal trays. Observation at 12:45 P.M. revealed LPN #2 was not wearing goggles or a face shield as she entered and exited resident rooms; she was wearing plastic glasses that were not enclosed on the sides. Further observation revealed goggles were available on the isolation carts. LPN #2 said she didn't know she had to wear goggles and she liked the glasses better. LPN #2 was aware there were goggles available as well as face shields. While LPN #2 was observed delivering lunch meals to residents she was observed touching and adjusting her N95 mask then touching the plastic utensils that were laying on top of the utility cart holding the meals, and pouring coffee. LPN #2 asked the surveyor if she needed to wear gloves to deliver the meals to residents in their rooms. The surveyor explained she should ask her administration if she was unclear on what Personal Protective Equipment (PPE) should be worn and when it should be worn. LPN #2 then applied gloves without performing hand hygiene and took a meal tray into the room of Resident #17. LPN #2 then picked up a meal tray to deliver to Resident #26 without performing hand hygiene. After LPN #2 opened the resident's door with the meal in hand she was reminded she was not wearing gloves. LPN #2 returned the meal tray to the cart and donned gloves. Interview with the Director of Nursing on 08/03/20 at 9:00 A.M. revealed they had 12 residents who tested positive for COVID-19 since 07/30/20 and they had five pending results. Observations on the COVID-19 unit on 08/03/20 at 11:30 A.M. revealed there were now 17 residents whom tested positive for COVID-19 residing on the unit. There were three LPNs staffing the unit, LPN's #2, #3, and #4. Observation of LPN #3 during meal pass at 12:30 P.M. revealed as she exited a room she removed her gloves, disposed of them in a trash barrel and put on clean gloves without performing hand hygiene. Interview with LPN #3 immediately after the observation while she went to pour drinks from the coffee cart confirmed she had not performed hand hygiene between changing gloves and leaving the resident 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.