STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365215	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUBURBAN HEALTHCARE AND REHABILITATION	20265 EMERY RD NORTH RANDALL, OH 44128

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 observation, interview, review of nursing home guidance from the Centers for Disease Control (CDC), record review, review of facility education and policy review, the facility failed to implement appropriate precautions for new admissions/ readmissions on the high observation unit and failed to ensure staff and residents used personal protective equipment (PPE) to properly prevent potential spread of COVID-19. This affected 13 of 112 facility residents that resided on the high observation unit (Residents #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38 and #39). Findings include: 1. Observation of the second floor of the facility on 07/29/20 starting at 9:58 A.M. revealed a central nursing station with three separate hallways containing resident rooms. The middle hallway, or high observation unit, was noted to have plastic sheeting with a zipper door to enter the remaining area of the hallway. No signage was outside of this barrier indicating what PPE was required to enter this unit. Once inside the plastic barrier there were two more plastic sheets with zipper doors to enter the resident care area. On the right hand side, an open three tier cart had several isolation gowns, a box of gloves and a laminated sign stating an N95 (respirator mask) was required. On the wall above this cart were printed out diagrams showing staff how to don and doff PPE. No face shields or goggles, extra N95 masks or shoe coverings were available for use. Observation on the high observation unit on 07/29/20 at 10:00 A.M. revealed no designated area to discard used PPE. No signage on any of the resident rooms (Rooms 227, 228, 229, 230, 231, 232, 233 and 234) indicated if any of the residents were on isolation precautions or what PPE was required to enter these resident rooms. No additional PPE was readily available on the unit. State tested Nursing Assistant (STNA) #109 exited a resident room after providing care and the only PPE STNA #109 was noted to be wearing was an N95 respirator mask. Observation exiting the high observation unit on 07/29/20 at 10:06 A.M. revealed Culinary Director (CD) #112 coming through the third plastic zipper barrier with only a mask as PPE. Interview on 07/29/20 at 9:13 A.M. with the Administrator and Assistant Administrator (AA) #102 revealed the facility did not have any residents that were COVID-positive at this time. Per facility practice, any residents with signs and symptoms of COVID-19 were sent to the hospital to be tested ; those who tested positive did not come back to the facility. On the second floor of the facility, new admissions/readmissions had rooms on the high observation unit. No PPE was required on the high observation unit except a mask. Interview on 07/29/20 at 9:46 A.M. with Occupational Therapist (OT) #107 revealed there were no other precautions on the high observation unit, as staff needed to wear just gloves and the N95 respirator mask. Interview on 07/29/20 at 9:48 A.M. with Licensed Practical Nurse (LPN) #108 revealed the high observation unit was for residents coming back from the hospital, where they would stay for 14 days. This unit did not include contact or droplet isolation. Interview on 07/29/20 at 10:00 A.M. with STNA #109 revealed they had rushed over to the high observation unit to provide care and verified they only had the N95 mask on. STNA #109 stated, all the other gear was needed to provide care on the unit, including a gown, gloves and shoe covers. STNA #109 verified there was not a biohazard bin available to discard PPE at the time of the interview and stated one had been on the unit over two weeks ago. Interview on 07/29/20 at 10:10 A.M. with STNA #110 revealed residents went in and out of the high observation unit often. Interview on 07/29/20 at 10:33 A.M. with CD #112 revealed the facility sent disposable Styrofoam containers and pre-packaged drinks for meals to the high observation unit. Dietary staff only took the meal carts to the floor to avoid potential exposure. CD #112 verified they had been on the high observation unit with only a mask on to speak to a new admission (resident not named) as there was no signage indicating gloves or a gown were required. Interview on 07/29/30 at 10:55 A.M. with Housekeeping and Laundry Director (HLD) #113 and Director of Maintenance (DOM) #104 revealed only an N95 mask and gloves were required to be worn on the high observation unit. Additional PPE was required if residents were suspected of having COVID-19. Phone interview on 07/30/20 at 10:30 A.M. with the Director of Nursing (DON) and the Administrator revealed when the facility had a positive COVID-19 case, that resident was sent to the hospital and would then discharge to a facility that was taking COVID-positive residents, then would return to the facility after 14 days and go on the high observation unit. The DON stated that a resident coming in from the hospital was like a resident coming in from the community thus were at a higher risk as someone could test negative for COVID-19 then later test positive for COVID-19. The DON stated standard precautions were in effect on the high observation unit which included gloves and the facility-required N95 mask. The DON stated some PPE was placed in the cart outside of the high observation unit in case staff needed it. Formal isolation kits were kept in the medication rooms that staff could ask another staff to go get. When asked regarding the lack of contact and droplet isolation on the high observation unit, the DON stated there was a fair amount of confidence all residents came to the facility (COVID-19) negative. The facility was not taking new admissions from the community at this time. When asked how a resident having multiple trips to the hospital was addressed within these guidelines, the DON stated the hospital would screen residents and if they thought a resident was positive then would test for COVID-19. The DON reiterated the facility presumed all residents coming to the high observation unit were negative for COVID-19 and the intent of the facility's practice was all residents coming to the unit were getting tested for COVID-19. Review of the current physician orders as of 07/29/20 for Residents #27, #28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38 and #39 revealed no orders for isolation precautions for fourteen days after admission to the facility. Review of the CDC's Responding to Coronavirus (COVID-19) in Nursing Homes (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) revealed all recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. A single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. Review of the facility policy, COVID-19 Protocol, dated 03/02/20 revealed standard, contact and droplet isolation would be initiated if symptoms develop with airborne precautions as indicated. Residents will be encouraged to stay in their room as much as they can tolerate and wear a face mask if they must leave their room. In general care for residents with undiagnosed respiratory infection use standard, contact and droplet precautions with eye protection. Provide the right supplies to ensure easy and correct use of PPE. Post signs on the door or wall of the resident room that clearly describe the type of precautions needed and required PPE. Make PPE, including facemasks, eye protection, gowns and gloves available immediately outside of the resident room and position a trash can near the exit of any resident room to make it easy for employees to discard PPE. The policy did not address the high observation unit, how to care for new admissions/re-admissions or what PPE was required when working with these residents. Review of facility education dated 03/06/20, 03/12/20, 03/17/20-03/19/20, 03/22/20 and 05/08/20 revealed staff received education on PPE use including how to don and doff PPE (gloves, gowns, masks and face shields) and received quizzes that asked about mask and glove use. 2. Review of Resident #37' s medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Review of census data indicated Resident #37 resided on the facility' s high observation

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) unit. Review of current physician orders revealed no order for isolation precautions for 14 days as a result of being a new admission or re-admission. An admission minimum data set (MDS) assessment dated [DATE] was still in progress at the time of the survey. Resident #37 utilized a wheelchair for mobility. Review of a nurses' note dated 07/22/20 at 8:05 P.M. revealed Resident #37 was readmitted to the facility. Review of a care plan revised 07/08/20 revealed Resident #37 was at risk for respiratory complications related to COVID-19 and associated risk factors including a national shortage of PPE. Observation status and refusal to wear a mask were not reflected in Resident #37's care plans. Observation exiting the high observation unit on 07/29/20 at 10:06 A.M. revealed Resident #37 self propelling his wheelchair through the three plastic zipper barriers, exiting the unit to go towards the elevator. Resident #37 did not have a mask on and was swearing at staff. Staff seated at the nurses' station including Licensed Practical Nurse (LPN) #105 and LPN #108 did not ask Resident #37 to wear a mask. Phone interviews were attempted with Resident #37 on 07/29/19 at 6:26 P.M. and on 07/30/20 at 9:22 A.M. but were unsuccessful. Phone interview on 07/30/20 at 10:30 A.M. with the Director of Nursing (DON) and the Administrator verified all residents should wear a mask if leaving the high observation unit. The DON was unaware Resident #37's care plan and nurses' notes did not reflect any documented refusals to wear a mask. Review of the facility policy, COVID-19 Protocol, dated 03/02/20 revealed residents will be encouraged to stay in their room as much as they can tolerate and wear a face mask if they must leave their room. This deficiency substantiates Complaint Number OH 466.