

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>366362</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>07/23/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>HUNTINGTON WOODS CARE &amp; REHAB CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>27705 WESTCHESTER PARKWAY WESTLAKE, OH 44145</b>	
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  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Provide and implement an infection prevention and control program.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on observation, interview and record review the facility failed to ensure staff washed/sanitized their hands after providing personal care and removing dining trays from isolation resident rooms. This affected two (Residents #66 and #18) of six residents who were in isolation. The facility census was 70 residents. Findings include: On 07/22/2020 at 9:42 A.M. during infection control observations on the first floor, a stop sign was observed on the door frame of room [ROOM NUMBER] which stated see a nurse before entering. There was also a small three drawer plastic dresser containing personal protective equipment outside of the door. Registered Nurse (RN) #50 was observed in room [ROOM NUMBER] taking the blood pressure of Resident #66. RN #50 asked the surveyor if she needed help with something. The surveyor asked her what infection Resident #66 had which required the sign and the personal protective equipment, and RN #50 explained yesterday was her first day and that she was unfamiliar with the residents but would check the computer. While waiting for the [DIAGNOSES REDACTED].M. the surveyor observed State tested Nursing Assistant (STNA) #40, going into room [ROOM NUMBER] and removing Resident #66's breakfast tray. The STNA exited the room and placed the tray on the cart then began to go into room [ROOM NUMBER], where Resident #18 resided and also had a sign on the door frame that stated see a nurse before entering. There was also had a small three drawer plastic dresser containing person protective equipment placed outside of the door. Before STNA #40 entered the room, the surveyor stopped her and asked her to sanitize her hands. The STNA then used hand sanitizer that she had in her pocket before proceeding into room [ROOM NUMBER]. RN #50 then said that it looked as if Resident #66 had [MEDICAL CONDITION]. RN #50 then began going through cart, and the surveyor asked her if she sanitized her hands after taking the blood pressure of Resident #66. RN #50 said there was no sanitizer in the resident's room, but she had sanitizer on her cart, however she did not sanitize her hands. Review of Resident #66's medical record revealed the resident was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. Physician orders [REDACTED].#66 for signs and symptoms of COVID-19 infection, such as fever and poor oxygenation, or unusual symptoms for the resident such as dry cough, tiredness, aches/pains, sore throat, other symptoms of respiratory infection, diarrhea, other symptoms of GI infection, [MEDICAL CONDITION], headache, loss of taste or smell, rash on skin, and discoloration of fingers or toes. Progress notes dated 07/04/2020 indicated Resident #66 had bilateral [MEDICAL CONDITION] requiring an antibiotic, [MEDICATION NAME]. Review of Resident #18's medical record revealed the resident was admitted on [DATE] with a [DIAGNOSES REDACTED]. Physician orders [REDACTED]. of fingers or toes. Review of the Infection Control Policy and Procedure dated 11/28/2017 included Hand Hygiene Protocol that stated: a. All staff shall perform hand hygiene their when coming on duty, between resident contacts, after handling contaminated objects, after PPE removal, before/after eating, before/after toileting, and before going off duty. b. Staff shall perform hand hygiene before and after performing resident care procedures and per our facility's established hand hygiene procedure. Both RN #50 and STNA #40 had gone into a room designated as requiring isolation and did not wash or sanitize their hands upon exiting the room after providing resident care services and removing meal trays from the resident's bedside table.</p>		

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.