

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 395442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2020
NAME OF PROVIDER OF SUPPLIER MANORCARE HEALTH SERVICES-YORK NORTH		STREET ADDRESS, CITY, STATE, ZIP 1770 BARLEY ROAD YORK, PA 17408	
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 - Few	Provide and implement an infection prevention and control program. Based on observation and interview it was determined that the facility failed to follow infection prevention practices during the screening process, to prevent potential cross contamination and potential exposure, for individuals entering the facility during the COVID-19 pandemic. Findings include: An observation on August 25, 2020, at 9:00 a.m. of the screening process revealed Employee 1, without wearing PPE (personal protective equipment), opening the front door to allow entry of this writer. Employee 1 then walked behind the reception area, that did not have a barrier and then leaned forward to take this writer's temperature, without any PPE. The pen that was used to complete the screening questionnaire was pulled from a container behind the reception area, and was returned to the area without being disinfected. The Nursing Home Administrator informed this writer, in the reception area, that all employees are to be wearing a facemask and eye shield/goggles while in the facility. During an interview with the Nursing Home Administrator and the Director of Nursing on August 25, 2020, at approximately 9:30 AM they agreed that the screener should be wearing a face mask, face shield/goggles, and gloves during the screening process, and that pens should be disinfected between use by persons being screened. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 207.2(a) Administrator 's responsibility 28 Pa. Code 211.10(d) Resident care policies		

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.