STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115382	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPARTA HEALTH AND REHABILITATION	11744 HIGHWAY 22 E SPARTA, GA 31087

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 -** Immediate jeopardy **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, interviews, review of facility policy, and record review, the facility failed to ensure residents negative for COVID-19 were not housed with residents positive for COVID-19 for two out of 12 sampled residents (R#4 and R#6). Additionally, the facility failed to ensure staff were able to identify which residents were positive for COVID-19 and failed to ensure all personal protective equipment (PPE) was used while caring for residents positive for COVID-19. The facility documented 37 residents as positive for COVID-19 and six residents as negative for the COVID-19 virus. The census was 43. On June 17, 2020 at 6:15 p.m. a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's Administrator, Director of Nursing (DON), Infection Preventionist (IP), and the Regional Nurse were informed of the immediate jeopardy on June 17, 2020 at 6:15 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on May 30, 2020 and continued through June 17, 2020. An acceptable Immediate Jeopardy Removal Plan was validated on June 18, 2020. The immediate jeopardy was outlined as follows: The immediate jeopardy was related to the facility's noncompliance with the program requirements at 42 C.F.R. 483.80(a) Infection Prevention and Control Program (F880, Scope/Severity: K). The facility's failure to ensure residents testing negative for COVID-19 were housed in rooms separate from residents testing positive for COVID-19, staff were able to identify which residents tested positive and which tested negative for COVID-19, and staff followed infection control guidelines for Transmission Based Precautions (TBP) constituted an immediate jeopardy at F880. An Immediate Jeopardy Removal Plan was received on June 18, 2020. Based on observations, record reviews, interviews, and review of the facility's policies as outlined in the Immediate Jeopardy Removal Plan, it was validated that the corrective plans and the immediacy of the deficient practice was removed on June 18, 2020. The facility remained out of compliance at a lower scope and severity of E while the facility continued management level staff oversight of resident placement and infection control. This oversight process included the analysis of facility staff's conformance with the facility's Policies and Procedures for Infection Control Transmission Based Precautions. In-service materials and records were reviewed. Observation and interviews were conducted with staff to ensure they demonstrated knowledge of facility Policies and Procedures governing Admission Policies and Procedures for cohorting residents and Infection Control Practices. The immediate jeopardy Removal Plan was validated through observation, interview of staff, and review of in-service records. The immediate jeopardy Removal Plan included placing R#4, who tested negative, in a room with a resident negative for COVID-19 and placing R#6, who refused testing, in a private room. Additionally, isolation precaution signs were removed from rooms where residents had tested negative (two tests in a row) and staff were educated about identification of and proper PPE usage for residents positive for COVID-19. Observations included room assignments of residents testing negative for COVID-19, verification of signage for rooms of residents testing positive for COVID-19, and observations of staff wearing gowns when entering rooms of residents testing positive for COVID-19. Interviews with staff validated knowledge to follow both droplet and contact precautions whenever entering resident rooms who tested positive for the COVID-19 virus. Findings include: During the entrance interview on 6/17/20, the IP provided documentation of facility wide COVID-19 testing. The first testing was done between 4/23/20 and 5/11/20 and the second round of testing was done between 5/21/20 and 5/30/20. The IP confirmed the process for deciding when a resident comes off of Transmission Based Precautions (TBP) was determined by two negative COVID-19 tests in a row. A third facility wide testing was conducted on 6/16/20 and the results were available later in the day on 6/17/20. During the tour of the facility on 6/17/20 at 2:00 p.m., equipment slings with PPE were observed on all of the resident room doors. Signage for TBP included Droplet Isolation and Barrier (Contact) Isolation. The facility provided a list of dates and results of COVID-19 tests for all the residents in the facility. Review of the COVID-19 results revealed R#4 tested negative for the COVID-19 virus on 5/06/20 and 5/30/20. Review of the COVID-19 results revealed R#4 was roommates with a resident who tested positive for the COVID-19 virus on 5/30/20. Further review of the list of COVID-19 results revealed R#6 had refused to be tested and therefore had an unknown COVID-19 status. Review of the list of COVID-19 results revealed R#6 was roommates with a resident who had tested positive for COVID-19 on 5/6/20 and on 6/11/20. On 6/17/20 at 1:40 p.m., Licensed Practical Nurse (LPN) AA verbalized that if a negative COVID-19 tested resident was roomed with a positive test, to pull the curtain between the residents and provide care to the negative tested resident first. Barrier precautions (use of the gown) was limited to direct patient contact. On 6/17/20 at 1:42 p.m., the LPN BB verbalized that in resident room [ROOM NUMBER] of the three residents one tested negative for the COVID-19 virus and the other two tested positive. LPN BB stated, The residents do not have much interaction with each other, so it was okay to have them in the same room. On 6/17/20 at 1:45 p.m., Certified Nursing Assistant (CNA) CC entered room [ROOM NUMBER] without donning a gown to pick up used lunch dishes. CNA CC verbalized there were two negative COVID-19 residents and one positive housed in the room. CNA CC stated, A gown is used only if there is close contact with the resident. These interviews revealed that LPN BB and CNA CC were instructed to follow the signs on the rooms for what type of TBP and PPE were required for the residents but were not able to correctly identify the residents' COVID-19 status. On 6/17/20 at 1:50 p.m., the Environmental Services Aide DD entered room [ROOM NUMBER] and came out with a bag of trash, then performed hand hygiene, and entered room [ROOM NUMBER] (across the hallway from 101) and brought out the trash. room [ROOM NUMBER] and 114 had TBP signage and PPE on the doors indicating positive COVID-19 status of the residents. The Environmental Services Aide verbalized she was supposed to put on a gown when entering the room but had been instructed that the gowns were only for use during direct resident care. On 6/17/20 at 1:55 p.m., the Laundry Aide EE went into room [ROOM NUMBER] to deliver personal laundry. She went into the room without donning a gown. The Laundry Aide verbalized she should have put on a gown but did not. room [ROOM NUMBER] housed residents positive with COVID-19. On 6/17/20 at 3:15 p.m., the IP confirmed droplet precautions meant to use a mask and goggles and contact precautions included donning gown and gloves. The IP verified the signs outside each room included the specific instructions and the staff were expected to wear mask, goggles, gloves, and gowns when entering rooms. Review of in-service records dated 2/18/20, revealed staff read a copy of an untitled memo, dated 2/14/20, that instructed staff to place residents suspected of COVID-19 on contact and droplet isolation. Review of in-service records dated 5/6/20, revealed nurses were to keep a list of positive COVID-19 residents and staff were to treat all residents with droplet and universal precautions. Review of in-service records dated 5/20/20, revealed staff were to review the signs posted as they indicate the PPE to be used for entering the resident rooms. On 6/18/20 at 11:30 a.m., the Regional Infection Preventionist (RIP) verbalized, in a telephone interview, the staff were instructed to use droplet precautions at all times (wear a face mask) and gowns only for direct resident care, to save on gown usage. Review of policy Transmission Based Precautions dated November 2019, indicated, . place together in the same room (cohort) residents who are infected with the same pathogen. Avoid placing residents on Droplet Precautions in the same room with residents who have conditions that may increase the risk of adverse outcome from infection or that may facilitate transmission . Review of policy Transmission Based Precautions dated November 2019, indicated Droplet precautions included face mask covering and

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) eye protection. Barrier or contact precautions included wearing gown and gloves.