STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115265	A. BUILDING _____ B. WING _____	**09/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARBORVIEW SATILLA	**1600 RIVERSIDE AVE WAYCROSS, GA 31501**

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, record review, and review of the facility's policies titled, Isolation-Categories of Transmission-Based Precautions, review of the facilities policy titled, American Health Care Association (AHCA) COVID-19: Screening Checklist for Visitors and Staff, and review of the Centers for Disease Control and Prevention (CDC) Preparing for COVID-19 in Nursing Homes the facility failed to ensure an effective infection control program to prevent the spread of the coronavirus (COVID-19) was implemented for 23 out of 82 total residents. Licensed Practical Nurse (LPN) AA failed to wear a N95 or equivalent facemask while administering medications to residents that resided on the Wisteria Blvd unit (where residents that had recovered from COVID-19 resided) and Honeysuckle Avenue unit (where residents that had not tested positive for COVID-19 resided). Findings include: Review of the Centers for Disease Control and Prevention (CDC) Preparing for COVID-19 in Nursing Homes, dated 6/25/2020, revealed healthcare personnel (HCP) should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Cloth face coverings should not be worn by HCP instead of a respirator or facemask if personal protective equipment (PPE) is required. Review of the facility's policy titled Isolation-Categories of Transmission-Based Precautions, dated October 2018, revealed transmission-based precautions were initiated when a resident developed signs and symptoms of a transmissible infection; arrived for admission with symptoms of an infection or had a laboratory confirmed infection; and was at risk of transmitting the infection to other residents. Standard precautions were used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-based precautions were additional measures that protected staff, visitors and other residents from becoming infected. The CDC maintained a list of diseases, modes of transmission and recommended precautions. Review of the facility's American Health Care Association (AHCA) COVID-19: Screening Checklist for Visitors and Staff, revised 3/31/2020, revealed on 3/13/2020 Center for Medicare & Medicaid Services (CMS) and CDC updated guidance on restricting all skilled nursing facility (SNF) visitors and non-essential healthcare personnel (HCP), except for certain [MEDICATION NAME] care situations. Continued review revealed that when there were cases of COVID-19 in the facility or sustained transmission in the community, the facility was to implement universal use of facemask for all HCP while in this facility and consider having HCP wear all recommended personal protective equipment (PPE) (gown, gloves, eye protection, N95 respirator or, if not available, a facemask) for the care of all residents, regardless of presence of symptoms. Review of the facility's Midnight Census Report, dated 9/9/2020, revealed 10 residents occupied beds on Honeysuckle Avenue unit; 13 residents occupied beds on Wisteria Blvd unit; 19 residents occupied beds on Azalea Road unit; 10 residents occupied beds on Dogwood Trail unit; 11 residents occupied beds on Rose Lane unit; and 19 residents occupied beds on Sunflower Lane unit. Review of the facility's Confirmed (Active) COVID-19 Cases, document received on 9/10/2020, revealed 13 residents that resided on the Azalea Road unit were diagnosed with [REDACTED]. Continued observation of LPN AA on 9/9/2020 at 8:50 p.m., on the Honeysuckle Avenue unit, revealed she stood at the medication cart in the hallway wearing a black cotton facemask, without a surgical or N95 or equivalent facemask underneath it. Further observation revealed a sign posted on the zipped barrier wall to the Wisteria Blvd unit that read, Must wear an N95 mask or KN95 mask at all times when in care areas. Interview with LPN AA on 9/9/2020 at 8:55 p.m., revealed she was assigned to the residents on Honeysuckle and Wisteria units and was hired four weeks ago through a nursing staffing agency. Continued interview revealed she was not aware that she could not wear her own facemask in the facility and had been wearing it while working the last four weeks. LPN AA stated she was not educated on the facility's policy to wear a surgical, N95 or equivalent facemask in resident care areas. Further interview on 9/10/2020 at 3:35 p.m., revealed she was not asked to remove her store-bought facemask and wear the facility's facemask when screened at the back-door entrance. LPN AA stated that it was important to wear the facility's facemask to prevent the spread of [MEDICAL CONDITION]. Interview with the Receptionist on 9/10/2020 at 3:51 p.m., revealed she was hired one month ago to screen staff using the AHCA COVID-19 Screening Checklist at the back-door entrance at 2:45 p.m., 6:45 p.m., and 10:45 p.m. Continued interview revealed she checked the staff's temperature and recorded the results; asked staff to use the alcohol-based hand rub (ABHR); asked staff if they had a fever, sore throat, cough, new shortness of breath; and asked staff if they had worked in facilities or locations with recognized COVID-19 cases. The Receptionist stated that she was ensuring that the staff had a facial covering on but had not been trained to ask staff to remove their own facial covering and wear the facility's N95 mask. Further interview revealed that she had N95 facemasks available when she screened staff at the entrance; however, she only provided staff with a facemask if they didn't have a facemask. Interview with the Infection Preventionist (IP) on 9/10/2020 at 12:30 p.m., revealed she expected staff to wear the proper PPE and follow the CDC guidelines. The IP stated it was the responsibility of the Nurse Educator to educate staff on infection control practices; however, the Nurse Educator had resigned a week ago. The IP stated that new staff were assigned a preceptor for a couple of days to orient them to the facility and the electronic medical record (EMR). Further interview revealed the LPN should have known to wear the N95 mask in the facility because there were signs posted to wear it everywhere and she had provided one on one education to staff when she had seen staff not wearing their masks appropriately. The IP stated the facility had two (2) coronavirus outbreaks so it was important to wear the appropriate facemask to prevent the spread of [MEDICAL CONDITION]. Interview with the Director of Nursing (DON) on 9/10/2020 at 4:37 p.m., revealed that she supervised the nurses and nursing assistants and expected them to wear a N95 or KN95 when in resident care areas according to the CDC guidelines. The DON stated the facility experienced two outbreaks of the coronavirus in July and August. The DON stated 15 residents that resided on the Azalea unit had COVID-19 and 13 residents that resided on Dogwood Trail unit had either recovered from COVID-19 or were under investigation for COVID-19. Continued interview revealed the Nurse Educator educated staff on the infection control policies to don and doff the PPE correctly. Continued interview revealed the day receptionist had trained the night Receptionist to ensure that staff wore a N95 or KN95 mask, not their own mask, before working in the resident care areas as stated on the COVID-19 staff screening form. Interview with the Administrator on 9/10/2020 at 4:51 p.m., revealed he was responsible for all the facility staff and residents. Continued interview revealed he expected staff to follow the infection control policy to wear either an N95 or KN95 facemasks. The Administrator stated staff were aware that they were supposed to wear the N95 or KN95 facemask when providing care to the residents.

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.