STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425410	A. BUILDING _____ B. WING _____	09/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKYLYN NURSING AND REHABILITATION CENTER	1705 SKYLN DRIVE OFC SPARTANBURG, SC 29307

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections for one (1) of five (5) residents on transmission based precautions (TBP) out of a total sample of nine (9) residents (Resident #11). Observation on 9/1/2020 revealed Certified Nursing Assistant's (CNA's) #1 and #2 failed to wear the proper eye protection prior to entering Resident #11's room. In addition, observation on 9/1/2020 revealed CNA #2 failed to don and doff the personal protective equipment (PPE) in the correct order before entering and exiting Resident #11's room. Moreover, observation on 9/1/2020 revealed the incorrect transmission-based precautions (TBP) signage was posted on the outside of Resident #11's room. The findings include: Review of the facility's policy titled, Isolation-Initiating Transmission-Based Precautions, revised October 2018, revealed transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. The Infection Preventionist identifies the type of precautions, the anticipated duration, and the PPE that must be used, and determines the appropriate notification on the room entrance door so that personnel are aware of the need for and type of precautions. Review of the facility's policy titled, Isolation-Categories of Transmission-Based Precautions, dated October 2018, revealed droplet isolation may be implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning). Review of the Centers for Disease Control and Prevention (CDC) Sequence for Putting on Personal Protective Equipment (PPE) and How to Safely Remove PPE, undated, revealed the type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE. Sequence for putting on PPE: 1. Gown 2. Mask or Respirator 3. Goggles or Face Shield 4. Gloves How to safely remove PPE example 2: 1. Gown and Gloves 2. Goggles or Face Shield 3. Mask or Respirator 4. Wash hands or use an alcohol-based hand sanitizer immediately after removing all PPE Review of Resident #11's clinical record revealed he/she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #11's Physician Order, dated 8/25/2020, called for droplet precautions and follow-up appointment with his/her surgeon. Review of Resident #11's care plan, updated 8/24/2020, revealed droplet isolation and PPE per policy. Review of Resident #11's Consultation Report, dated 8/24/2020, revealed Resident #11 attended a surgery follow-up appointment at 1:00 p.m. Review of the in-service signature form titled Don/Doff PPE, dated 6/15/2020, revealed CNA #1 and #2 had received training on the CDC's Sequence for Putting on Personal Protective Equipment (PPE) and How to Safely Remove PPE. 1. Observation of Certified Nursing Assistant (CNA) #2 on 9/1/2020 at 2:09 p.m., outside of Resident #11's room, revealed he/she donned a KN95 mask, gloves and gown then entered the room. Continued observation revealed CNA #2 opened Resident 11's door, stepped outside of the room, removed the mask and discarded it in the trash bin inside the resident's room, and removed the gown and gloves then discarded them in the trash bin inside the resident's room. Further observation revealed a sign on the door contact isolation - wear gown, gloves, face mask, and face shield. Interview with CNA #2 on 9/1/2020 at 2:15 p.m., revealed he/she was assigned to Resident #11 over the weekend and the contact precautions sign was on the door then. The CNA stated Resident #11 was on contact precautions because he/she tested positive for the coronavirus (COVID-19) in the past. Continued interview revealed he/she didn't don the face shield because he/she didn't see the face shield under the gowns on the bedside table outside of Resident #11's room. The CNA stated that he/she had not received training on donning and doffing PPE at the facility; however, he/she learned the sequence for donning and doffing PPE in CNA courses. CNA #2 stated he/she donned the face mask, gloves, and gown before entering the resident's room. The CNA also stated that he/she removed the gown, gloves, then mask then discard in trash bin inside the resident's room before exiting the room. 2. Observation on 9/1/2020 at 2:15 p.m. outside of Resident #11's room, revealed CNA #1 donned a gown, KN95 mask and gloves then entered Resident #11's room. Further observation revealed a sign on the door contact isolation - wear gown, gloves, face mask, and face shield. Interview with CNA #1 on 9/1/2020 at 2:24 p.m., revealed that Resident #11 was on contact precautions because he/she tested positive for the coronavirus. The CNA stated that he/she was trained by the Director of Nursing (DON) to don the gown, face mask, gloves then face shield before entering the resident's room. Continued interview revealed to doff the face shield, gown, then gloves before exiting the resident's room. CNA #1 stated he/she didn't see the face shields were under the gowns on the bedside table. Further interview revealed that PPE had been available, and the nurses restock it before every shift. The CNA stated it's important to follow the precautions to prevent the spread of [MEDICAL CONDITION]. Interview with the Unit Manager (UM) on 9/1/2020 at 3:11 p.m., revealed that he/she supervised the nurses and was not aware that the CNAs were not wearing face shields or putting on and removing PPE in the correct sequence. The UM stated that he/she was hired two (2) days ago and would be training staff on infection control. Further interview revealed that it's important to follow the TBP to eliminate and reduce the risk of cross contamination. Interview with the Director of Nursing (DON) (also served as the Infection Preventionist) on 9/1/2020 at 3:30 p.m., revealed that Resident #11 should have had a droplet precautions sign posted on door not the contact precautions sign since he/she went out for a follow-up surgery appointment on 8/24/2020. The DON stated that when residents return from appointments, they must be placed on droplet precautions in a private room for 10 days to prevent the spread of the coronavirus. Continued interview revealed he/she provided training to all staff during orientation, annually and monthly in-services on TBP and donning and doffing PPE correctly. The DON stated he/she has been monitoring staff's competency and compliance with the infection control practices on a monthly basis. Interview with the Administrator on 9/4/2020 at 11:22 a.m., revealed he/she was responsible for all of the facility staff and residents. Continued interview revealed he/she expected staff to follow the infection control policy on transmission-based precautions and the CDC guidelines on donning and doffing PPE. The Administrator also stated that he/she was not aware that staff had not donned and doffed in the correct sequence and that infection control in-services have been provided for staff at least monthly.

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.