STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115535	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE CITY NURSING AND REHABILITATION CENTER LLC	2055 REX ROAD LAKE CITY, GA 30260

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 observations, interviews, and policy and procedure reviews, the facility failed to: 1. Implement hand hygiene and gowns changes between meal tray deliveries on hall 600, where both COVID positive and COVID negative residents resided, which increased the risk of spread of infection throughout the hall. 2. Quarantine residents going out of the facility for appointments upon their return to the facility, which increased the potential spread of infection. The facility reported 9 residents who received [MEDICAL TREATMENT] treatments outside the facility on a regular basis, which increased their exposure to COVID-19. Four of the residents had tested COVID positive and were in isolation, the other 5 residents (Residents (R) R#1, R#6, R#7, R#8, and R#9), remained in the general population of the facility and were not quarantined. 3. Establish donning and doffing stations for personal protective equipment (PPE) on halls 200, 300, 600, 700, and 800. 4. Limit resident access between COVID-19 positive and COVID-19 negative areas by allowing access to the outdoors from the COVID-19 positive section of hall 200 to the COVID-19 negative section of hall 200, and to limit access to the COVID-19 positive hall 300 for one resident (Resident (R)#5) who was COVID-19 positive. R#5 did not perform hand hygiene after re-entering the building after smoking. The deficient practices increased the potential spread and risk of exposure to COVID-19 for the 191 residents receiving care in the facility. At the time of the survey the facility reported 54 residents who were COVID-19 positive. Findings include: 1. During an observation of hall 600 on 8/27/20 at 12:59 p.m., at the double doors to enter the hall, an undated sign was posted that specified:COVID-19 Personal Protective Equipment (PPE) for Health Care Personnel . N95 or higher respirator . face shield or goggles . gloves .isolation gown .face masks are an acceptable alternative The hall was observed to be a mixed hall with both COVID-19 positive and COVID-19 negative status residents. The COVID-19 positive status residents were in rooms [ROOM NUMBER]. On the doors of rooms [ROOM NUMBER] were signs that read, Stop: Droplet precautions, N95, face shield, double gown required. All other rooms held COVID-19 negative status residents. At the double door there was no available PPE, other than a large table containing brown paper bags which held the individual outer plastic disposable gowns for each staff. The PPE had to be obtained from the Unit Manager whose office was nearby. During the observation Licensed Practical Nurse (LPN) HH had to acquire a cloth gown from the Unit Manager. The doffing station was located immediately inside the double doors and the COVID-19 positive residents were located further down, near the end of the hall, on the right side of the hall. a. During an observation of meal tray delivery on hall 600, beginning on 8/27/20 at 11:18 a.m., Certified Nurse's Assistant (CNA) EE had donned PPE, including gloves, but failed to conduct hand hygiene or change gowns between tray deliveries as follows: CNA EE entered room [ROOM NUMBER] (a COVID-19 positive room,) and delivered the tray to the bedside table. Without sanitizing her hands or removing her gloves she then delivered a tray to room [ROOM NUMBER]B (a COVID-19 positive room) and set the tray on the bedside table. Without conducting hand hygiene, she moved over to set up the area for the resident in 613A (a COVID-19 positive room.) CNA EE raised the head of the bed, moved the bedside table in front of the resident, went back to the meal cart, and delivered the meal tray to 613A. CNA EE set up the meal and placed a napkin of the chest of the resident. Without performing hand hygiene, CNA EE went to room [ROOM NUMBER]B (a COVID-19 positive room,) where she set the tray on the bedside table and moved the table in front of the resident on the bed. Without conducting hand hygiene and without changing her first layer cloth gown or her outer layer plastic disposable gown, she delivered a tray to room [ROOM NUMBER]A (a COVID-19 negative room.) Without conducting hygiene or changing gowns, CNA EE then delivered a tray to room [ROOM NUMBER]B (a COVID-19 negative room,) where she set up the meal for the resident. CNA EE continued without hand hygiene or changing gowns while she delivered trays to rooms 610A, 604A, 606B, 607B, 610B, 616B, and 614B (all COVID-19 negative rooms.) At 1:35 p.m. a nurse came and whispered in CNA EE's ear; she then began conducting hand hygiene between tray deliveries but did not change her gowns. In an interview on 8/27/20 at 1:43 p.m., CNA EE said she had not been trained regarding PPE donning and doffing and said she should have performed hand hygiene between residents. Review of education for CNA EE showed she had been provided education for PPE use, donning and doffing, and hand hygiene. During an interview on 8/28/20 at 12:15 p.m., the DON said, Staff should sanitize their hands before each tray, and should have the outer gown on for COVID-19 positive rooms, but not COVID-19 negative rooms. The DON further said that ideally, one staff would pass to the COVID-19 residents, while another passed to COVID-19 negative residents, or pass to one then the other so they were wearing the proper PPE when they passed trays. Review of the policy Subject: Hand Washing, last revised 9/19, showed, .Staff will use proper hand washing technique to prevent the spread of infection. Review of the policy The Dining Experience: Objectives, undated, showed, . 12. Resident meals will be served in a sanitary environment with proper food handling procedures. 2. In an interview on 8/27/20 at 8:15 a.m., the Executive Director said she hadn't moved any of the [MEDICAL TREATMENT] residents because they were waiting for test results (for COVID-19) to come back on everyone. The Executive Director said, Today we are working on moving them to two unit (hall 200.) She said, If they test positive, they will be moved to the positive end of the hall. In an interview on 8/27/20 at 10:57 a.m., the DON said the facility had not been able to separate the [MEDICAL TREATMENT] patients who were not currently COVID-19 positive from the general population. She said, When the [MEDICAL TREATMENT] patients return from treatment they are screened by the nurse for vitals and symptoms, but they return to their regular rooms and were not quarantined. Four of nine [MEDICAL TREATMENT] patients in the facility were COVID-19 positive at the time of the survey. Review of a list of [MEDICAL TREATMENT] residents, provided by the facility, showed 5 of 9 [MEDICAL TREATMENT] residents, R#1, R#6, R#7, R#8, and R#9, were COVID-19 negative, but had not been quarantined after receiving treatments in the community. All [MEDICAL TREATMENT] residents were assigned to rooms with a roommate and had not been relocated for COVID-19 precautionary measures. In an interview on 8/27/20 12:40 p.m., the Executive Director said she didn't think people going out to appointments (including [MEDICAL TREATMENT] residents) are covered by the policy and procedures. She said, Starting today we will put people going out for appointments in quarantine, like the [MEDICAL TREATMENT] people. The Executive Director later provided a policy, Admission and PPE Guidance, undated, that read, If resident goes to the ER/outpatient and returns the same day, place on DU (designated unit) for 14 days and monitor symptoms. On 8/27/20 at 4:32 p.m., she said, Today we are moving the [MEDICAL TREATMENT] patients to put them in quarantine. 3. All rooms housing COVID-19 positive patients were required to observe droplet precautions. Observations of halls 200, 300, 400, 600, 700, and 800, showed the following: a. Review of the policy, Subject: Droplet Precautions, last updated 9/19, showed, . 2. Outside the room place a cart (or unit affixed to the room door) containing a covered supply of gowns, gloves, masks, and plastic bags, and, . Procedure: . 3. Apply protective equipment as indicated before entering the room . a. Gloves - utilized during the course of providing care. Change gloves when having contact with infective material as they may contain high concentration of micro-organisms . Remove gloves before leaving resident's room and wash hands. C. Gowns - apply gown before entering the room . remove the gown before leaving the room . In an interview on 8/27/20 at 8:00 a.m., the Executive Director said, KN95 masks are used for three to four days, and staff use a washable and disposable gown. She said the PPE could be changed as needed. In an interview on 8/27/20 at 8:00 a.m., the Director of Nursing (DON) said, N95 masks are used for COVID positive patients and AGP's (aerosol generating procedures.) On 8/27/20 at 9:00 a.m.,

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) the DON said the facility used two gowns, a first layer that was a cloth gown and a second layer that was a disposable plastic gown. The disposable plastic gown was placed in a brown paper bag and reused, even when going between halls. b. During an observation and interview on 8/27/20 at 9:07 a.m., a barrier was set up between rooms [ROOM NUMBERS] on hall 200. Beyond room [ROOM NUMBER] were housed COVID-19 positive residents. All donning and doffing of PPE for hall 200 was conducted outside of room [ROOM NUMBER], in the COVID-19 negative resident area. In this area, staff removed their outer disposable plastic gown and gloves that were used in the COVID-19 positive area of hall 200 and placed the disposable plastic gown in a brown paper bag to be reused upon reentry to the COVID-19 positive section of hall 200. The Infection Preventionist described this process and said the facility was trying to conserve PPE. She said, We do move between halls using the same outer gown. We use them about three days, but they can be changed if soiled or damaged. The PPE station did not contain the disposable plastic gowns, masks, or shields. c. During an observation and interview on 8/27/20 at 9:40 a.m., Kitchen Staff (KS)FF delivered a meal tray to room [ROOM NUMBER] (in the positive COVID-19 section of hall 200,) and was not wearing gloves or the required disposable plastic gown. At 9:42 a.m., KS FF said she did not wear gloves to deliver trays. The DON directed KS FF to go and get a plastic disposable gown to wear. d. During an observation and interview on 8/27/20 at 9:42 a.m., Resident (R)#5, in room [ROOM NUMBER] (the COVID-19 positive section,) wanted to go out and smoke. R#5 said he smokes, Out in the yard three or four times a day. At 9:58 a.m., R#5 was observed going out of the facility through hall 300 donning/doffing room, which was located immediately to the left of the double doors leading to hall 300, and lead to a courtyard. R#5 was accompanied by a staff member and another resident. He was wearing a surgical mask. At 10:15 a.m., R#5 came back through the donning/doffing room on hall 300 to return to hall 200 and did not sanitize his hands upon entry to the area of hall 300. Residents of hall 300 were all COVID-19 positive residents. R#5 then proceeded through the hall 200 COVID-19 negative section to the COVID-19 positive section. Review of a copy lab results, provided by the facility, showed R#5 had tested positive for COVID-19 on 8/12/20. 4. During an observation on 8/27/20 at 9:55 a.m., in the donning/doffing room for hall 300, there were no first layer cloth gowns or other PPE available. Two blue disposable plastic gowns were hanging from hooks on the wall. 5. Observations of hall 800, a hall reserved for observation of newly admitted residents, had signage which showed, to enter hall 800, you must wear PPE and don the PPE prior to entry into the hall. a. During an observation and interview on 8/27/20 at 10:30 a.m., at the entrance to hall 800, with double doors, there was no available PPE, and the area did not have a station set up for donning and doffing. Once on the hall, a laundry cart was observed, near room [ROOM NUMBER], at the center of the length of the hallway (four rooms down) that contained the clean first layer cloth gowns. There was no observed available second layer disposable plastic gowns, gloves, masks, or goggles. At 10:40 a.m., the DON said staff would have to get the PPE from their supervisor. She said they could not set up a PPE station by the double doors of hall 800 because, it would be a fire hazard. To doff there was no available garbage or biohazard can for gloves or disposable plastic gowns. A laundry cart, used to place the first layer cloth garment in when doffing, was found by room [ROOM NUMBER]. At 10:51 a.m., the DON rearranged the carts to be closer together. 6. During an observation off hall 700, and interview on 8/27/20 at 2:00 p.m., the Unit Manager (UM)FF said staff needed to use the area for donning and doffing that was near hall 600 because the facility lacked space enough for hall 700 to have a station set up. Immediately outside of hall 700 there was no PPE station or supplies available for donning PPE, or area for doffing PPE.