STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115534	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AZALEALAND NURSING HOME	**2040 COLONIAL DRIVE SAVANNAH, GA 31406**

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, interviews, record review, and policy review, the facility failed to ensure staff followed infection control policies related to transmission-based precautions for one of five residents (R) (#1) observed for infection control practices. Certified Nurse Aide (CNA) AA cared for a resident positive for COVID-19 and removed the resident's contaminated drinking cup without ensuring proper disposal and handling. Findings include: Review of the facility's Covid 19 Operational Guideline, revised on 7/19/20, directed If any resident is considered suspicious for COVID-19 as determined by RN or MD, that resident will be placed in isolation . airborne/ contact precautions will be implemented immediately. Confirmed positive residents will be isolated in the COVID care area with airborne + contact precautions with the fire doors closed. The resident will have face mask during close personal care if coughing. Review of a Nurse's Note dated 7/29/20 at 1:17 p.m. in the Charting Notes tab in R#1's electronic health record (EHR) documented the resident was positive for Covid 19 and placed in isolation. Review of a COVID-19 Test Result Summary obtained from the medical record dated 7/29/20 documented that a nasopharyngeal (nose and throat) swab obtained on 7/27/20 was positive for [DIAGNOSES REDACTED]-CoV-2/2019-nCoV (COVID-19). Observation on 8/4/20 at 11:30 a.m. revealed the facility had a dedicated COVID Unit. Posted on the closed fire doors to the COVID Unit, were signs titled AIRBORNE/CONTACT PRECAUTIONS and CONTACT/DROPLET PRECAUTIONS directed that EVERYONE MUST . USE DEDICATED OR DISPOSABLE EQUIPMENT. During an observation on 8/4/20 at 2:33 p.m. on the COVID Unit, CNA AA entered R#1's room to perform incontinence care. CNA AA was already wearing an N95 mask, long sleeved gown, and face shield and donned gloves upon entering the room. While providing incontinence care the resident had several episodes of non-productive coughing with positional changes and was not wearing; nor offered a mask. At the completion of the incontinence care the resident asked CNA AA for water. CNA AA removed the soiled gloves, used alcohol-based hand rub (ABHR), re-gloved, entered the resident's room, and obtained a white 12 oz Styrofoam cup from the resident's bedside table. The CNA exited the room with the Styrofoam cup and placed it on a nightstand table in the hall (clean area). CNA AA removed gloves, used ABHR, got the Styrofoam cup from the nightstand, went to the nurse's station, and got ice from a small cooler with a scoop, and water from the sink. CNA AA re-gloved and entered the resident's room to give her the water. During an interview on 8/4/20 at 2:40 p.m., CNA AA stated she did not know why she got the used disposable cup from the resident's room and stated she should have used a clean cup. During an interview on 8/4/20 at 3:10 p.m., the Infection Control Nurse stated that all residents on the COVID Unit are on transmission-based precautions and the contact and droplet precautions signs are utilized by the facility to denote that. The Infection Control Nurse stated that since R#1 was on transmission-based precautions, the CNA should not take the cup that was in the resident's room outside of the room; she should have used a clean cup. In addition, the Infection Control Nurse stated that action contaminated the clean surface and she would make sure it was cleaned right away.

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.