STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. BUILDING _____ B. WING _____	**08/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER	**176 LINCOLN AVE FITZGERALD, GA 31750**

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 -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy entitled Infection Control Policy re: [MEDICAL CONDITION], the facility failed to update the infection prevention and control policies and procedures (IPCP's) addressing use of eye protection when providing care to residents. Failure to have updated written processes places all current in-house residents residing in the non-COVID (99 out of 103 residents) unit at risk for contracting and transmitting COVID-19. There were four (4) of 103 residents positive with COVID-19 at the time of the survey. The facility also failed to ensure proper use of personal protective equipment (PPE) by staff working in four (4) of the five (5) nursing units. The staff failed to wear eye protection to prevent the potential spread of COVID-19. The facility failed to ensure signage for transmission-based precautions was posted to alert staff before entering one (1) of one (1) resident room who was on isolation and not in the quarantine unit (Resident #3). Lastly, the facility failed to store two (2) of five (5) ice scoops in a sanitary manner and failed to ensure all five (5) hydration carts were cleaned and disinfected daily. This failure placed all residents at risk for contracting infectious illnesses. The findings include: 1. During an interview with Certified Nursing Assistant (CNA) #1 at the East Hall nurses' station on 08/20/20 at 11:20 AM, she stated goggles or face shields were optional when caring for residents. CNA #1 stated she did not think the facility had any face shields. Observation of Licensed Practical Nurse (LPN) #1 on South A Hall on 08/20/20 at 11:45 AM revealed the LPN was in and out of resident rooms and in the nursing station with other staff without wearing eye protection. During an interview on 08/20/20 at 12:00 PM at the East Hall nurses' station with the Director of Nursing (DON), who is also the Infection Control Preventionist (ICP), she revealed she was not aware of the Center for Disease Control (CDC) guideline, dated 07/15/20, about eye protection. She stated the COVID unit is the only area where eye protection is required, and it was optional in the other areas. She stated the facility had enough supply of face shields for staff use. Observation of LPN #2 on the East Hall nurses' station on 08/20/20 at 2:10 PM revealed the LPN was in and out of resident rooms without wearing eye protection. Review of facility's policy entitled, Infection Control Policy re: [MEDICAL CONDITION], dated 02/28/20 documented . Our facility will follow those directions as given and will enforce CDC (Center for Disease Control) guidelines regarding health care providers. Review of the facility's COVID-19 Protocol Phase 11, effective date 03/2020 documented . Procedure, Once a case of COVID-19 has been confirmed in your county or an adjacent county, please review and implement Pandemic Pathogen Plan as appropriate . Policy to ensure compliance with CDC guidelines while reducing the chance of COVID-19 exposure to residents. Review of the CDC's guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic, Infection Control Guidance, updated 07/15/2020, indicated, For HCP working in areas with minimal to no community transmission, HCP should continue to adhere to Standard and Transmission-Based Precautions, including use of eye protection . 2. Review of Nursing Admission Note, dated 08/11/20, revealed Resident #3 was re-admitted to the facility on [DATE] and placed on droplet precautions on the East Hall in a private room. Resident #3 was observed on 08/20/20 at 11:15 AM in a private room with a three-drawer plastic container that contained gowns and gloves just outside of the room. There was no signage on the door or anywhere near the room alerting staff the resident was on any type transmission- based precautions. The East Hall is not part of the quarantine unit. During an interview with the DON/ICP on 8/20/20 at 11:15 AM, she stated Resident #3 had been readmitted from the hospital and had been placed on droplet precautions. She stated he had not tested positive for COVID and did not have any symptoms. She did not know what happened to the signage on his door. During an interview with CNA #1 on 08/20/20 at 11:20 AM, she stated goggles are optional on the floor and when entering a droplet isolation room. She said she was assigned to Resident #3 today and was aware Resident #3 was a new admission on quarantine. She further stated she did not wear eye protection on her shift and did not think the facility had any face shields. 3. On 08/20/20 at 11:20 AM, CNA #1 was observed on the East Hall filling a resident's large green water bottle with ice. She placed the scoop in direct contact with the opening of the container to fill it with ice. After filling it with ice she gave it back to the resident who proceeded to return to his room. CNA #1 confirmed she should not have touched the resident's water bottle with the scoop. She proceeded to take the scoop into the clean utility room and rinsed it off under the sink. She then brought the scoop back to the hydration cart and placed it back into the open blue plastic container attached to the side of the cart. Observation of the East and South B Hall nourishment cart with the DON/ICP on 08/20/20 at 11:45 AM revealed both scoops were stored in an open container in the hallway. The DON/ICP confirmed the ice scoop should be in a closed plastic bag and not in the open container. She stated it was the responsibility of the kitchen staff to ensure the scoops are in the closed plastic bag. During an interview in the conference room with the Dietary Manager on 08/20/20 at 4:08 PM, she said the CNA's on the units are supposed to bring the hydration carts to the kitchen to be cleaned and sanitized (ice chest with ice, and scoop) after breakfast and after dinner. She stated the ice chests are sanitized with bleach, then the scoop and ice chests are run through the dish machine. The scoop is placed in a sealed plastic bag and placed inside of the clean ice chest. Staff pick up the ice chest with plastic sealed scoop and return it to the unit. She stated there was no written policy, but she presented the undated Dietary cart cleaning schedule. The form indicated, Clean and wipe with disinfectant wipes .Hydration cart: 9:00 AM-9:30 AM, 7:00PM-7:30PM. The written schedule did not specify who was responsible it was to take the hydration carts to the kitchen and back to the units. The written cleaning schedule did not document the process of cleaning and disinfection the hydration carts. During an interview with the Dietary Aid on 08/20/20 at 4:25 PM, she stated her hours are from 12:30 PM to 8:00 PM, and since her hire date of 06/01/20 she had not cleaned the hydration carts. She said staff had never brought them to the kitchen to be cleaned. During an interview on 08/20/20 at 4:50 PM with CNA #2 on the East Hall, she stated she worked the evening shift and was not aware she was supposed to take the hydration cart to the kitchen for cleaning.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE