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 _____	07/02/2020

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of facility documents and review of facility policy, the facility failed to maintain and implement an effective infection prevention and control program (IPCP). Specifically, 1. The facility failed to sanitize one of three thermometers (a temporal scan thermometer) used in the employee and visitor entrance lobby screening area for Coronavirus 2019 (COVID-19). 2. The facility failed to consistently complete COVID-19 symptoms screening forms for all employees for one of four months (June 2020). Months March 2020 through June 2020 were reviewed. During the month of June 2020, the facility was screening temperatures and were not consistently screening for symptoms of [MEDICAL CONDITION]. 3. The facility failed to follow proper contact isolation precaution guidelines with relation to the personal protective equipment (PPE) isolation cart placement for two of two resident rooms observed and reviewed for isolation practices. This failed practice had the potential to create cross contamination of the Coronavirus and other contagious diseases for both residents and staff. Findings include: 1. During observation located on the facility lobby, on 07/01/20 at 9:45 AM Concierge #1 was observed using a handheld temporal thermometer (Medisim brand name) (a thermometer that touches a person's temple to read their temperature) while obtaining the first surveyor's temperature reading. Prior to obtaining the first surveyor's thermometer reading, Concierge #1 was observed sanitizing the thermometer with a sanitizing spray (Citra Cen brand name disinfecting spray) that had a dwell time (the amount of time that a surface must remain wet to allow the chemical to be in contact with the organism in order to kill it) of five to ten minutes. Concierge #1 sprayed the sanitizer on a tissue and wiped the surface of the temporal thermometer's scan point that touches the person's temple. Concierge #1 then obtained the temperature reading of the second surveyor, touching the surveyor's temple and then wiped the thermometer's scan point with the same tissue that was used to sanitize the thermometer for the first surveyor. During an interview on 07/01/20 at 10:00 AM, Concierge stated, the Citra Cen disinfectant spray was used and was sprayed on a tissue used for wiping the thermometer's scan point that touches the person's temple. Concierge #1 was not aware of the manufacturer's recommendations for cleaning the temporal thermometer nor had read the Citra Cen instructions for use located on the back of the spray can. Concierge #1 stated, there was no education offered or provided for the use of the temporal thermometer or the disinfectant spray. During an interview on 07/01/20 at 10:00 AM, Concierge #2 (also responsible for employee and visitor screenings at the lobby entrance doorway), stated he/she was not aware of the manufacture's recommendations for cleaning the temporal thermometer nor the proper disinfectant to use when sanitizing the thermometer. There were no educational instructions provided on cleaning the temporal thermometer or the use of the disinfectant spray. Review of the Citra Cen disinfecting spray can's instructions on the back of the can, revealed the spray was a .Tuberculocidal, Fungicidal, Bactericidal and Viricidal spray . The instructions indicated that the spray could be harmful if absorbed through the skin and to wash skin thoroughly with soap and water after handling. The instructions included dwell times (dry time to be effective) for the different types of organisms being killed. The dwell times were from five to ten minutes. Review of the temporal thermometer brand Medisim manufacturer's recommendations located online at https://www.manualslib.com/manual/ 17/Medisim-Fht1.html#manual revealed, .It is important to clean after each use . .Wait two minutes before taking another temperature to allow the thermometer to re-adjust to room temperature . .Wipe tip and probe with alcohol swab or cotton swab with 70% [MEDICATION NAME] alcohol before and after each use . During an interview on 07/01/20 at 10:09 AM the Director of Nursing/Infection Control Preventionist (DON/ICP) stated he/she was not aware the lobby screening area had a temporal scan thermometer being used or that the disinfectant spray was being used to clean the thermometer. It was revealed after further investigation and interview that the facility had an infrared thermo scan thermometer designated for the lobby screening area that was lost as of a few days prior to the survey. It was confirmed by the DON/ICP there was no infection control education or training provided for the temporal thermometer or the cleaning of it. 2. Observation on 07/01/20 at 10:38 AM on the skilled unit revealed, a resident was being brought back from an out of the facility appointment and was brought through the skilled unit entrance doorway by three ambulance transportation employees. Review of the COVID-19 Temperature Screening and Symptoms Screening forms located on the skilled unit with the DON and Registered Nurse (RN) #1 revealed, the ambulance transportation employees had not completed the symptoms screening forms for that visit. The symptoms screening forms were further reviewed against the daily nursing schedule for 07/01/20 and it was revealed all employees working had a temperature screening recorded for that day, however, not all employees working had completed symptom screening forms. There were no screening forms located for the month of June 2020. The months of March 2020 through June 2020 were reviewed. There were no identified inconsistencies with the temperature screening recordings for the months of March 2020 through June 2020. During an interview on 07/01/20 at 10:38 AM with Registered Nurse (RN) #1 revealed, all temperature screenings were recorded on the daily staffing sheets and if a symptoms screening form was completed, it would be recorded on the daily staffing sheet also. RN #1 stated, employees and vendors (such as hospice and ambulance drivers) entering the skilled unit entrance doorway from the outside should stop at the nurse's station and get their temperature taken and fill out a symptoms screening form. The symptom screening forms were not being completed every time with every employee. RN #1 added, the therapy department performed their own screenings and kept their own temperature screening logs. During an interview on 07/01/20 at 10:50 AM the Physical Therapist (PT) stated, the therapy department was recording their employee temperatures on a log and kept in a binder that is located in the therapy department. They were not always completing the symptoms screening form. When and if a screening form was completed it would be placed in the file box at the nurse's station. The PT stated, the therapy employees entered the facility from the back of the building through the laundry and kitchen hallways and then through the skilled unit internal doorway across from the nurse's station. The employee would then have their temperature taken at the nurse's station or go to the therapy department and have their temperature taken and record it in the binder. During an interview on 07/01/20 at 11:05 AM the Ambulance Transport (AT) #1 stated, he/she was screened for a temperature, however, no symptoms screening form was completed. During an interview on 07/01/20 at 11:05 AM, AT #2 and AT #3 stated, they were supposed to be screened upon entering the facility skilled unit doorway, however, they were not screened prior to picking up the resident on that day. Later, in the interview it was clarified by AT #2, they were screened for temperatures but had not completed a symptoms form screening and were not sure why the facility wasn't completing those. The temperature screenings were verified by RN #1 after the interview. During an interview on 07/01/20 at 2:03 AM the DON stated, he/she had no formal training on infection control (IC) practices. The Administrator was training him/her, and the Administrator had the formal training in infection control and had a certification and was responsible for the facilities IC program. Review of the facility's policy titled Full COVID Protocol dated 05/07/20 revealed, all staff were to be screen prior to entering their shift and daily. Review of an email adopted into the facility's COVID-19 policy titled, COVID 19 Precautions: Reach Out if you Need Help! dated 03/17/20 revealed, . Daily Staff Screenings (ALL STAFF). All communities must be doing daily screening and temp checks on all staff members . Review of the facility's policy titled, Coronavirus / COVID-19 Preparedness and Response Plan dated 05/07/20 revealed, .All persons entering the community must be screened for signs and symptoms or possible exposure

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) to COVID-19 . .Screening should include taking the temperature of each person as they arrive at the community . .Temperatures should be taken using a reliable touch less thermometer. Should one not be available, then an ear or other thermometer must be used, use an appropriate probe cover and disinfect according to manufacturer instructions . Review of the facility's undated screening form titled, COVID-19 Screening revealed, the screening form had a designated place for the person being screened name, date and shift, a designated place for temperature recording and a designated place for symptoms and exposure questions answered to be recorded. The directions on the form stated, .For the safety and wellbeing of our residents, if the answer to any of the following are yes, please speak with the Executive Director or supervisor. Thank you . 3. During an observation on 07/01/20 at 11:00 AM it was revealed, there were two resident rooms designated by signage that were in contact isolation for non-COVID 19 diagnoses. Both isolation room doors were closed with signage on the door to don PPE prior to entering the rooms related to the specific contact isolation diagnosis. There were no PPE stations or carts located on the outside of the rooms. Additional observations were made when both rooms doors were opened, the PPE and biohazard receptacles were located on the inside of the resident's rooms and the staff would have to enter the infected room to don PPE. During an interview on 07/01/20 at 11:25 AM at the nurse's station with the DON/ICP and RN #1 it was stated, the proper procedure for contact isolation was prior to entering the resident's room the staff should don PPE appropriate per policy and care being provided. The DON/ICP and RN #1 stated, the facility had only one door hanging PPE station and that was why they placed the PPE inside the rooms of the residents in contact isolation. They stated, they were not sure if they could place PPE in some type of container outside the doorway in the hallway. They stated, they were knowledgeable that the PPE should be located and donned prior to entering the resident's room to reduce the risk of exposure of the infection. Both nurses confirmed that the facility policy and procedure was to place the PPE on the outside of the room and the current placement would be an infection control concern. Review of the facility's infection control policies and procedures titled, Isolation - Initiating Transmission-Based Precautions dated October 2018 revealed, the facility would .Ensure that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment; . During an interview on 07/02/20 at 8:00 AM the DON/ICP confirmed the COVID-19 Screening form should have been used consistently with all staff and visitors per the direction of the facility's policy and procedures. He/she stated, the Administrator had been tracking and trending the facility temperatures and the residents monitoring and screening information related to COVID-19, however, the DON/ICP could not recall why or who gave the direction to stop the symptoms screening form and complete only screening temperatures for the month of June 2020. In addition, the DON/ICP confirmed the survey findings to be a concern and would be addressed immediately and that the facility policies and procedures provided during survey were accurate and current.