STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115524	A. BUILDING _____ B. WING _____	08/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE PAVILION AT BRANDON WILDE	4275 OWENS ROAD EVANS, GA 30809

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 observations, staff interviews, record review and review of the facility's policies entitled Admission Policy: COVID-19 and Isolation-Initiating Transmission Based Precautions, the facility fail to ensure three (3) of six (6) sampled residents (Resident #'s 1, 2 and 5), wore masks when outside of their rooms to prevent the potential spread of infection. In addition, the facility failed to implement transmission based precautions, post isolation status and have personal protective equipment (PPE) readily available for use for three (3) of six (6) sampled residents (Resident #'s 1, 2, and 5) who were newly admitted and considered in quarantine. The findings include: Review of the facility's policy entitled, Admission Policy: COVID-19, with no date, revealed Residents must have COVID-19 test results provided to the community (facility) prior to admission. If the COVID-19 test was negative, the admitting resident must quarantine for 72 hours following admission. The policy did not provide instructions for staff for the type of isolation that was required during the 72 hour quarantine nor did it instruct staff as to what PPE should be worn when caring for the residents which increased the risk for the spread of COVID-19. Review of the Electronic Medical Record (EMR) under the Face Sheet Tab revealed Resident #1 was admitted to the facility on [DATE]. Review of Resident #1's Clinical Record revealed a negative COVID-19 test dated 08/18/20 while in the hospital. On 08/21/20 at 11:35 AM, during the tour of the building, Resident #1 was observed in their room with the door open. There were no signs for droplet and contact precautions on the resident's room door. There was no PPE outside the room. On 08/22/20 at 10:00 AM, the door to Resident #1's room was open, had PPE supplies suspended on the door by a metal hanger, and the resident was not visible from the door. The DON/Infection Preventionist entered the room, without donning any additional PPE to speak to the resident. The DON/Infection Preventionist was wearing only a face mask. On 08/22/20 at 10:01 AM, the DON/Infection Preventionist confirmed that full PPE should have been donned prior to entering the room since Resident #1 was a new admission and quarantined. Review of the EMR, under the Face Sheet Tab, revealed Resident #2 was admitted to the facility from the assisted living facility on 08/20/20 at 10:00 AM with an unknown COVID-19 status. Resident #2 was not tested for COVID-19 prior to admission to the facility, per the facility policy. The resident was admitted to a private room and placed on quarantine for 72-hours. Quarantine was defined, by the facility, as residents were to remain in their room and were monitored for signs and symptoms of COVID-19 infection due to the potential exposure prior to admission to the facility. The policy did not define the precautions that should be in place while a resident was quarantined. Review of the Clinical Notes for Resident #2, located in the EMR under the Notes tab, revealed the responsible party had consented to a COVID-19 test and the resident was tested using the rapid COVID-19 test at 7:56 PM on 08/20/20, approximately ten hours after admission to the facility. The results of the test were negative. On 08/21/20 at 11:20 AM, during the tour of the Arbor unit of the building, Resident #2 was standing in the doorway of the room calling out to the staff. Resident #2 was not wearing a mask. There were no signs for droplet and contact precautions on the resident's room door. There was no PPE outside the room, although the resident was quarantined. On 08/21/20 at 11:15 AM, during the tour of the building, eight (8) unsampled residents in the Arbor unit were socially distanced at different tables and in wheelchairs in the common area of the unit. All of them had face masks and were wearing the masks under their chin not covering their nose and mouth. During the observation, upon inquiry, the DON/Infection Preventionist verbalized the residents were to be encouraged and reminded by the staff to wear their masks when they were out of their room. She did not redirect the resident's to place the masks over their noses and mouths. The facility did not provide a policy regarding the wearing of face masks by residents. Review of the EMR, under the Face Sheet tab, revealed Resident #5 was admitted to the facility on [DATE] with an unknown COVID-19 status. Review of the Clinical Notes for Resident #5, located in the EMR under the Notes tab, and revealed his wife consented to a COVID test on 08/20/20, after he was admitted . On 08/21/20 at 11:05 AM, during the tour of the building, Resident #5 was in his room with the door open. There were no signs for droplet and contact precautions on the resident's room door. There was no PPE outside the room. On 08/21/20 at 11:06 AM, Licensed Practical Nurse (LPN) #1 entered Resident #5's room wearing a mask and gloves. On 08/21/20 at 12:55 PM, LPN #1 verbalized when admitted to the unit a resident was placed on quarantine for 72 hours and staff were to use universal precautions and wear a mask and gloves when providing care. On 08/21/20 at 12:50 PM, Certified Nursing Assistant (CNA) #1 verbalized when residents were admitted to the facility from the hospital they were to stay in their room and full PPE was to be worn. CNA #1 stated she was not wearing full PPE because she was not caring for any residents on isolation. The CNA did not verbalize knowledge of the 72 hour isolation or which PPE should be worn when a resident was quarantined. On 08/21/20 at 10:15 AM, the Administrator and the Director of Nursing (DON), who was also the facility's Infection Preventionist explained the process for new admission and readmission residents. Those admitted from the hospital tested negative for COVID-19 prior to admission to the facility. Those admitted from the assisted living buildings on the property were placed in quarantine without a COVID-19 test prior to admission. They were admitted to a private room and placed on quarantine for 72-hours. Quarantine was defined, by the facility, as residents were to remain in their room and were monitored for signs and symptoms of COVID-19 infection. On 08/21/20 at 10:15 AM, the DON/Infection Preventionist verbalized when quarantine was implemented the resident stayed in their private room for three days and staff used universal precautions (face masks and gloves) when entering the resident room for care. The facility practice was to use universal precautions for all the residents regardless of a potential exposure to COVID-19 prior to admission to the facility. Review of the facility's policy titled Isolation-Initiating Transmission Based Precautions, dated October 2018, revealed Transmission-Based Precautions are initiated when a resident .arrives for admission .and is at risk of transmitting infection to other residents.

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.