STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115537	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RENAISSANCE CENTER FOR NURSING AND HEALING	**415 AIRPORT ROAD GRIFFIN, GA 30223**

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 and document review, the facility failed to ensure staff wore gloves and performed hand hygiene in rooms on the COVID-19 positive unit. Also failed to ensure staff discarded a sugar packet after picking it up off the floor on the COVID-19 positive unit and mingled the soiled packet with other packets available for resident use. This had the potential to affect 14 of 14 residents on the COVID-19 positive unit. The finding include: Review of the facility census revealed the facility had 14 residents residing on the COVID-19 positive unit at the time of the survey. 1. On 09/02/20 at 9:35 AM, an observation revealed a plastic barrier between the area for doffing/donning Personal Protective Equipment (PPE) and the COVID-19 unit. Certified Nursing Assistant (CNA) #11 was observed passing a handful of sugar packets under the plastic barrier to Licensed Practical Nurse (LPN) #12. One of the sugar packets fell on the floor in the COVID-19 unit, LPN #12 picked it up and mixed it with the other packets of sugar. During an interview with LPN #12 on 09/02/20 at 10:00 AM, she verified she picked the packet up off of the floor and mixed it in with the other packets. She stated she placed the sugar packets on a table in the staff room for resident use. The sugar packets were observed on a bedside stand in an employee room. The Infection Preventionist/Assistant Director of Nursing (IP/ADON) was present during the observation made at 9:35 AM on 09/02/20. The IP/ADON was also present during the 10:00 AM interview on 09/02/20 with LPN #12, and verified the nurse should not have picked the packet up off the floor and mixed it back in with the other packets. 2. On 09/02/20 at 10:41 AM, CNA #7 was observed on the COVID-19 positive unit passing out papers to residents in their rooms. She did not wear gloves when she entered room [ROOM NUMBER] and touched the over-bed table which contained two beverages in Styrofoam cups and was visibly soiled. Without washing her hands or putting gloves on, she went directly to resident rooms #'s 134 and 129, again touching the residents' over-bed tables with her ungloved hands. In room [ROOM NUMBER], she turned on a television station, using the remote with her ungloved hands, and then returned to the hall. During interview on 09/02/20 at 10:48 AM, CNA #7 verified she touched the over-bed tables and used a remote control to change television stations. She also verified she did not have gloves on and did not wash and/or sanitize her hands between each of the rooms. CNA #7 stated she did not feel like it was necessary since she was just passing out papers. On 09/02/20 at 6:10 PM, this finding was shared with the Director of Nursing and the Administrator. They stated staff were supposed to wear gloves when entering resident rooms and were expected to change the gloves and perform hand hygiene between resident rooms. Review of the an undated document titled, Empire Care Centers Patient-specific Contact + Airborne Precautions for Special Respiratory Circumstances, which was posted on the wall of the hallway on the COVID-19 unit, revealed the staff were required to wear gloves upon entering residents' rooms and to perform hand hygiene before and after contact with the resident's environment.
F 0885 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and family interviews, the facility failed to inform resident representatives and/or families of a single confirmed infection of COVID-19 by 5:00 PM the next calendar day following the occurrence of receiving the results; failed to include information on mitigating actions implemented to prevent or reduce the risk of transmission; and failed to assure that residents, their representatives, and families were able to access cumulative data at least weekly. This failure affected four (4) of four (4) sampled residents. The findings include: Review of Data Collection Line Listing for Respiratory Outbreaks for 04/20 through 08/17/20 revealed effective on 08/12/20, the facility had their first positive case of COVID-19. During an interview with the Administrator on 09/02/10 at 5:00 PM revealed they were notified of the positive test results on 08/14/20. According to the Administrator, the facility had no evidence, other than what was documented in the medical record, to prove when the residents or their responsible parties were notified. The records of four (4) sampled residents were reviewed for notification of the first positive case of COVID-19 and for testing for COVID-19. Review of the records revealed the following: 1. Review of Resident #1's medical record contained no evidence that the resident's representative/family was notified by 5:00 PM on 08/15/20 after the facility learned that a resident had tested positive for COVID-19 on 08/14/20. Review of Resident #1's CAPSTONE Healthcare Respiratory Microbiota Report revealed a COVID-19 swab was collected on 08/18/20 and was received by the laboratory and processed on 08/20/20. According to the results, the resident was positive. review of the resident's medical record revealed [REDACTED]. The note stated the responsible party (RP) was notified of the resident being COVID positive and was also informed that 16 residents and six (6) staff members were COVID positive. The note did not include evidence that the responsible party was notified of mitigating actions implemented to prevent or reduce the risk of transmission. The note informed the RP to use the website to keep updated. During an interview on 09/02/20 at 5:30 PM, this note was shared with the Director of Nursing (DON). She confirmed this was the only documentation in the medical records related to responsible party notification. She verified there was no proof that the RP was notified within 24 hours of the facility receiving the 08/14/20 results of the first positive resident nor that they were informed of mitigating actions. Review of Resident #1's medical record contained no evidence that the resident's representative/family was notified by 5:00 PM on 08/15/20 after the facility learned that a resident had tested positive for COVID-19 on 08/14/20. 2. Review of Resident #2's medical record revealed a note written by the Activity Director dated 09/02/20 at 4:41 PM, was the only documentation notifying the RP of positive COVID-19 test results. The note was a follow-up to the 08/24/20 communication where the RP was notified that the resident tested negative. The RP was notified that 16 residents and six (6) staff tested positive and was referred to the website to keep updated. During an interview on 09/02/20 at 5:35 PM, this note was shared with the Director of Nursing (DON). She confirmed this was the only documentation in the medical records related to responsible party notification. She verified there was no proof that the RP was notified within 24 hours of the facility receiving the 08/14/20 results of the first positive resident nor that they were informed of mitigating actions. 3. Review of Resident #3's medical record contained no evidence that the resident's representative/family was notified by 5:00 PM on 08/15/20 after the facility learned that a resident had tested positive for COVID-19 on 08/14/20. The record contained a note dated 08/24/20 at 2:35 PM, which informed the RP of 16 positive residents and sic (6) positive staff members at the facility. The note failed to provide evidence that the RP was provided any information related to mitigating actions which the facility took in response to the outbreak. On 09/02/20 at 5:52 PM, the DON stated this was all she could locate in the medical record and both the DON and the Administrator stated they had no additional documentation to show the RP was notified within 24 hours of the facility's knowledge of its first COVID positive case. 4. Review of Resident #4's medical record contained no evidence that the resident's family/RP was notified by 5:00 PM on 08/15/20 when the facility learned that a resident had tested positive on 08/14/20. Review of Resident #4's CAPSTONE Healthcare Respiratory Microbiota Report revealed a COVID- 19 swab was collected on 08/18/20 and was received by the laboratory and processed on 08/20/20. According to the results, the resident was positive. review of the resident's medical record revealed [REDACTED]. The note provided no evidence the RP was notified of mitigating actions implemented to prevent or reduce the risk of transmission. The note referred the RP to the website to keep updated. On 09/02/20 at 5:58 PM, the note was shared with the DON. She verified there was no proof the responsible

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 0885 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	(continued... from page 1) party was notified within 24 hours of the facility receiving the 08/14/20 results of the first positive resident. Also that the RP was informed timely of Resident #4's 08/20/20 COVID positive test results or provided information about mitigating actions taken by the facility. On 09/02/20 at 6:10 PM, the Administrator stated they let families know information about COVID-19 per a web site; however, each family, resident or responsible party is not individually informed, and it is up to them to check the facility web site for updates. She stated they also post a letter on the front door of the facility; however, the facility was not allowing visitors into the facility at the time of the survey. Further interview with the Administrator revealed the facility had no evidence to show that they had educated families/RPs on how to access the web site for information about the facility's COVID-19 status and response, and had not determined that all families/RPs had internet capability to access this web site.