STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425047	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONDOR HEALTH ANDERSON	**611 EAST HAMPTON STREET ANDERSON, SC 29624**

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.** Based on observation, interview and record review, the facility failed to prevent the potential spread of communicable disease including coronavirus (COVID)-19, to four (4) of nine (9) sampled residents (Resident #s 6, #7, #8, and #9). Two staff members failed to sanitize vital sign equipment after each use per Centers for Disease Control (CDC) guidelines and facility policy. Findings include: 1. Observation on the COVID-19 Unit (Unit #1) on 8/25/2020 at 9:55 a.m. revealed two (2) Certified Nursing Assistants (CNAs), CNA #1 and CNA #2, entered the shared room of Resident #6 and Resident #7 with the portable vital sign machine. CNA #1 used the blood pressure cuff, securing it around the first resident's arm and obtained a blood pressure reading. CNA #1 removed the cuff then used the thermal thermometer, which touched the resident's forehead to read his/her temperatures. CNA #1 then used a pulse oximeter to obtain the oxygen saturations (O2 SATs), placing the device on the right index finger of the resident. Vital signs were obtained for the second resident in the same manner without disinfecting the equipment in between residents. CNA #1 and CNA #2 exited the room at 10:00 a.m. CNA #1 and CNA #2 failed to perform any cleaning or disinfection of the blood pressure cuff, thermometer, or pulse oximeter prior to or after exiting the residents' rooms. Residents #5 and #6 had tested positive for COVID-19 and were living on the COVID-19 Unit. CNA #1 and CNA #2 then entered the shared room of Resident #8 and Resident #9 with the portable vital sign machine at 10:00 a.m. CNA #1 and CNA #2 obtained the residents' blood pressures, used the thermal thermometer across both residents' foreheads to read their temperatures, and used a pulse oximeter to obtain oxygen saturations by placing it on the right index finger of both residents to check their vital signs. CNA #1 and CNA #2 exited the room at 10:10 a.m. CNA #1 and CNA #2 failed to perform any cleaning or disinfection of the blood pressure cuff, thermometer or pulse oximeter between residents, prior to entering or after exiting the residents' room. Residents #8 and #9 had tested positive for COVID and were living on the COVID-19 Unit. During an interview on 8/25/2020 at 10:25 a.m. with CNA #1 and CNA #2, CNA #1 stated, We can't disinfect the equipment if we don't have disinfection wipes and we don't have any disinfection wipes available. 2. Review of the facility's policy titled Cleaning and Disinfection of Resident-Care Items and Equipment dated April 2020 revealed the following: Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the Occupational Health and Safety Administration (OSHA) Bloodborne Pathogens Standard. Policy Interpretation and Implementation: Critical items consists of items that carry a high risk of infection if contaminated with any microorganism. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). 3. During an interview on 8/26/2020 at 3:00 p.m., Registered Nurse (RN) #1 stated he/she was also the Infection Control Nurse. RN #1 stated, (CNA #1 and CNA #2) should have cleaned all the equipment between residents. We have plenty of cannisters of disinfecting wipes and all the CNAs had to do is request for someone to bring them to them. 4. Review of the Nursing Competency: Non-Critical Equipment Use, Cleaning, and Disinfecting revealed CNA #1 and CNA #2 completed the competency correctly on 8/12/2020.

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