| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 115709 | A. BUILDING _____ B. WING _____ | 07/15/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **TWIN FOUNTAINS HOME** | **1400 HOGANSVILLE ROAD LAGRANGE, GA 30240** |

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) |
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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, review of training documentation, and review of facility policies, the facility failed to ensure housekeeping staff were aware of proper disinfection techniques in accordance with appropriate standard and transmission-based precautions to prevent the spread of Coronavirus (Covid)-19, on one of two facility wings, the South Wing. There were five residents who tested positive for Covid-19 residing on the South Wing. In addition, one mislabeled spray bottle of disinfectant was identified on the cleaning cart on the North Wing. Findings include: Review of a facility policy entitled, Transmission Based Precautions - Covid-19 (Published 4/10/2020) revealed a policy statement It is WellStar Health System's policy to follow Centers for Disease Control (CDC) on transmission-based precautions for Covid-19. The stated purpose was to define and update a process to control the spread of Covid-19 among patients, staff, visitors, and volunteers. Further review of policy revealed an Environmental policy and procedure change occurred (dated 2/26/2020 -3/10/2020) related to infection prevention regarding patient care equipment cleaning and low-level disinfectants. The policy contained a checklist for terminal cleaning of patient rooms and common areas. The checklist specified staff should use Oxycide (disinfectant) presoaked microfiber cleaning cloths. When using the disinfectant staff should ensure the surface was left sufficiently wet, to stay wet for the dwell time recommended by the manufacturer. A tour of the North Wing of the facility was conducted on 7/14/2020 at 10:45 a.m. There were no residents on the unit identified to be positive for Covid-19. Two residents in separate rooms were identified to be under contact precautions and personal protection equipment (PPE) was noted to be available outside of each resident room. There was one resident observed to be in the common area who was wearing a surgical mask. No other residents were observed to be out of their rooms. A cleaning cart was noted to be stationed in the hallway and a housekeeper GG was observed to be mopping a resident's room. Interview was conducted in a hallway of the North Wing on 7/14/2020 at 10:55 a.m. with Housekeeper GG. Housekeeper GG stated she was assigned to clean all residents' rooms and common areas on the North Wing. Housekeeper GG removed two spray bottles from the cleaning cart, indicating these were the disinfectants used. Observation of the two spray bottles revealed both were labeled as being Virex II 256; however, the liquids contained in each bottle were noted to be different colors. Housekeeper GG stated although each bottle was labeled the same, only one bottle contained Virex II 256 disinfectant. According to Housekeeper GG the second bottle contained a disinfectant called Oxycide. Housekeeper GG indicated the Oxycide disinfectant was stored in a large machine in the housekeeping closet and had to be poured out into a spray bottle. The facility did not have labels available to allow the Oxycide disinfectant to be properly identified and so she had used the mislabeled spray bottle. A tour of the South Wing was conducted on 7/14/2020 at 11:05 a.m. There were no residents observed to be in common areas or in the hallways of the South Wing. Interview conducted in the common area of the South Wing at 11:12 a.m. with a Licensed Practical Nurse (LPN) KK revealed there were five residents on the wing who were positive for Covid-19. According to LPN KK, the residents were confined to one end of the wing and there were empty rooms separating the positive Covid-19 residents from other residents who were negative for Covid-19. Observation revealed the positive Covid-19 residents were under droplet precautions and the appropriate PPE was being utilized by staff providing care for the residents. Interview was conducted on 7/14/2020 at 11:55 a.m. in the conference room with the Housekeeping Supervisor. The Housekeeping Supervisor stated she was responsible for cleaning the South Wing today. The Housekeeping Supervisor stated she used Oxycide disinfectant to clean resident rooms and the disinfectant was stored in a machine in the janitor's closet. The Housekeeping Supervisor confirmed there were no labels to properly identify the disinfectant when it was poured into a spray bottle for use. According to the Housekeeping Supervisor the labels had been ordered but had not arrived at the facility. The Housekeeping Supervisor stated she placed cleaning clothes into a green bucket and poured the Oxycide disinfectant onto the cleaning clothes, allowing them to soak up the disinfectant. She then used the Oxycide disinfectant soaked clothes to wipe off surfaces, followed immediately by using a dry cloth to wipe the disinfectant off the surfaces. Interview was conducted on 7/14/2020 at 2:52 p.m., via telephone, with the Housekeeping Director. The Housekeeping Director stated the disinfectants being used were qualified EPA-registered disinfectants for use against Covid-19. The Housekeeping Director indicated Oxycide came in a large dispensing container and labels for individual bottles come automatically with it. According to the Housekeeping Director, housekeeping staff had been trained in the proper use of Oxycide disinfectant, which was to use the provided green buckets and microfiber clothes. The microfiber clothes should be placed into the green bucket, and the Oxycide disinfectant poured in the bucket to saturate the microfiber clothes. Staff should then use the saturated microfiber clothes to wipe off all surfaces in the room/area being cleaned. It should then be allowed to air dry and should not be wiped off the surface. The Housekeeping Director stated he had conducted huddle training sessions with all housekeeping staff since the Covid-19 pandemic, but the biggest focus was on ensuring the proper use of PPE. Since the facility's cleaning/disinfecting process had not changed, the Housekeeping Director thought housekeeping staff were continuing to implement the proper procedure. The Housekeeping Director stated the facility had a monitoring system in place to determine all surfaces were being cleaned/disinfected. However, the Housekeeping Director stated he had not identified that housekeeping staff were not following facility procedures for proper use of the EPA-approved disinfectants. Interview was conducted on 7/15/2020 at 10:20 a.m. in the conference room with the Administrator. The Administrator stated the housekeeping services were monitored and housekeeping staff supervised by the Housekeeping Director. The Administrator stated the Housekeeping Director served as part of the Infection Control Committee and reported to the committee at each quarterly meeting. The Administrator stated the Housekeeping Director was also responsible for providing all housekeeping staff with in-service training pertinent to assigned job duties and responsibilities. Review of in-service training records revealed Housekeeper GG and the Housekeeping Supervisor both participated in facility provided training on 3/19/2020 and 4/30/2020 regarding Coronavirus and special pathogens and Personal Protection Equipment (PPE). Review of a facility manual titled Environmental Service Department, Housekeeping Safety Data Sheets (revised 9/4/2019) revealed a safety data sheet for Oxycide Daily Disinfectant Cleaner. The safety data sheet contained precautionary statements that included Take any precaution to avoid mixing with combustibles. Keep only in original container. Review of information obtained from the Environmental Protection Agency (EPA) government website (www.epa.gov) revealed when using disinfectants, the most important factor is the products' dwell time or contact time. The disinfectant needs time to breakdown all membranes that surround bacteria [MEDICAL CONDITION]. The EPA defines dwell time as the amount of time a sanitizer or disinfectant must be in contact with the surface and remain wet, in order to achieve the product's advertised kill rate. The contact time for Oxycide is three minutes. The facility's failure to ensure staff utilized EPA-registered disinfectant properly when cleaning surface areas of the facility increased the risk of the spread of infections to all residents, including the spread of Covid-19. |

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