STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425372	A. BUILDING _____ B. WING _____	**07/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHEA BAPTIST HEALTHCARE CENTER	**157 HOME AVENUE DARLINGTON, SC 29532**

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.** Based on observations, record reviews and interviews, it was determined the facility failed to ensure PPE (personal protective equipment) was removed and discarded prior to exiting a resident's room (Resident #1) under droplet isolation precautions and prior to leaving the PUI (Person Under Investigation)/COVID-19 positive unit for one of one therapy contract staff (Certified Occupational Therapy Assistant (COTA) #1) observed. This failure occurred during a COVID-19 pandemic. The findings included: A nursing progress note, dated 07/07/20 at 4:00 PM, indicated Resident #1 had been admitted to the facility on COVID-19 quarantine for 14 days related to, the current policy for admission. A care plan, dated 07/07/20, indicated Resident #1 required contact and droplet precautions due to a recent hospital stay and possible exposure to COVID- 19. A nursing progress note, dated 07/08/20 at 8:43 PM, indicated the resident remained on contact/droplet precautions. On 07/10/20 at 1:20 PM, COTA #1 was observed exiting Resident #1's room on the PUI unit wearing a face shield and a white disposable gown. She exited through the glass doors of the PUI/COVID-19 positive unit and proceeded walking down the facility hall, past a nurses' station, and then she turned the corner to the left, down a hall where COVID-19 negative resident rooms were located. Signs posted on the door to Resident #1's room included instructions to, Stop .Staff must .Discard gown before room exit . and Stop .Everyone must .Remove face protection before room exit . Immediately nursing staff in the vicinity were asked who the staff member was who had been observed exiting the unit wearing PPE, and they stated she was a member of the therapy staff. The surveyor proceeded to the therapy office/gym area and was joined by the ADON/IC (Assistant Director of Nurses/Infection Control Preventionist). On 07/10/20 at 1:21 PM, COTA #1 was observed sitting at a work area in the therapy gym wearing a white gown. She was asked if she had just completed therapy with a resident on the PUI unit. She stated Resident #1 had refused therapy because she had not felt well. She was asked if she was still wearing the same gown she had worn in the resident's room, and she said Yes. She was asked if she should have removed her gown and shield prior to leaving the resident's room and the PUI area, and she stated she probably was not a good person to ask because she had only been at the facility, about one week. She was asked if she knew if that resident was COVID-19 positive or negative, and she did not reply. Occupational Therapist, (OT) #1, who was also seated in the working area, stated Resident #1 had tested Negative for COVID-19. They were asked if they knew why Resident #1 was on isolation precautions. COTA #1 did not answer, and OT #1 stated the resident was being watched to see if she became COVID-19 positive. They were asked if there was a policy about removing PPE before leaving a resident's room in the PUI/COVID-19 positive unit, and they both stated they did not know. On 07/10/20 at 1:26 PM, the ADON was asked would it be acceptable for nursing staff to exit a resident's room under droplet isolation precautions or the PUI unit without removing and properly disposing of PPE, and she stated that would not be acceptable. On 07/10/20 at 1:40 PM, the Director of Rehabilitation stated therapy services were supplied by a (named) contract company. She stated COTA #1 was a new employee and had only been at the facility about one week. She stated COTA #1 had reported to her that Resident #1 was not having a good day and had refused therapy. She was asked if she expected COTA #1 to dispose of her PPE before leaving the resident's room, and she stated she would have expected her to remove her shield and gown before leaving the room. She said, Definitely, some education needs to happen. She was asked what kind of education or orientation was done for members of the contract therapy department, and she stated every morning she updated the team about PPE requirements and reminded them to look at the residents' room doors for PPE information. She was asked to provide the employee check off list for COTA #1 including any education about donning and doffing of PPE. On 07/10/20 at 2:25 PM, the Administrator (ADM) was made aware of the situation and acknowledged the concerns. He shook his head and stated, We have worked so hard. On 07/10/20 at 3:08 PM, the Director of Nurses (DON) was asked how the facility knew contracted therapy staff were properly trained to work in the PUI/COVID-19 positive unit, and she stated the Director of Rehabilitation made sure. On 07/10/20 at 3:18 PM, COTA #1 was interviewed a second time. She stated she put on a fresh disposable gown prior to entering Resident #1's room. She stated she did not remove her gown because she had not worked with the resident. She stated she had not touched the resident but had only talked with her. She stated the (named) rehabilitation contract company had provided education on how to work in the facility. Education, On-Boarding and Check-Off documents for COTA #1, provided by the (named) contract company, were reviewed and did not indicate she had been trained on when and how to properly remove PPE. No documentation was provided which indicated the new contract employee was competent for the proper donning and doffing of PPE for use in a PUI/COVID-19 positive unit. During the Infection Control Focused Survey exit conference, on 07/10/20 at 3:30 PM, the ADM stated it would probably be a good idea to have the therapy contract staff complete the facility training.

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