STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425156	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKBROOK HEALTH AND REHABILITATION CENTER	920 TRAVELERS BOULEVARD SUMMERVILLE, SC 29485

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** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of facility policy, the facility Pandemic Prevention and Response Plan, and Center for Disease Control (CDC) information, the facility failed to test all residents for coronavirus (COVID)-19 in response to seven (7) nursing staff members testing positive for COVID-19. The facility experienced the first positive resident COVID-19 case on [DATE]. In response, the facility then tested 14 staff who worked with Resident #1 (the resident who initially tested positive) of which seven (7) tested positive for COVID-19. Between [DATE] through [DATE], 54 residents (Residents #s ,[DATE]) and 17 staff tested positive for COVID-19 which involved residents residing in 37 of 45 rooms. Six (6) the 54 residents testing positive for COVID-19 expired and eight (8) were discharged from the facility and admitted to Hospice care. The facility failed to update their Coronavirus policy to perform immediate testing of residents when an outbreak occurred after the facility experienced the outbreak of COVID-19 and in accordance with CDC recommendations. The facility's failure to update their policy had the potential to affect all residents of the facility. The findings include: Review of facility policy, Coronavirus Disease 2019 (COVID-19) dated [DATE], revealed in the event of a suspected or actual case of COVID-19, the facility initiates current recommended strategies for prevention of the spread of the disease and treatment methods. Review of the facility Coronavirus Disease 2019 (COVID-19) Pandemic Prevention and Response Plan dated [DATE], revealed the Infection Preventionist monitors CDC recommendations for pandemic prevention and response and coordinates post plan review after the first pandemic wave and implements changes to the response plan to improve outcomes for future waves. Review of CDC Website https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html dated [DATE], Diagnostic Testing revealed: Testing asymptomatic residents with known or suspected exposure to an individual infected with COVID-19, including close or expanded contacts (e.g., there is an outbreak in a facility). The facility should perform expanded [MEDICAL CONDITION] testing of all residents, in the nursing home if there is an outbreak in the facility. A single case of COVID-19 infection in a nursing home should be considered an outbreak. When there is one case detected in a nursing home, there are often other residents and health care personnel who are infected and can continue to spread the infection. Performing testing of all residents as soon as there is a confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of necessary interventions, (e.g., isolation, cohorting, use of personal protective equipment) to prevent COVID-19 transmission. Review of Oakbrook COVID Testing Board, provided by the facility documented the facility had received results that residents tested positive for COVID-19 on the following dates: Resident #1 -[DATE] Resident #2 -[DATE] Resident #3- [DATE] Resident #4- [DATE] Resident #5- [DATE] Resident #6- [DATE] Resident #7- [DATE] Resident #8- [DATE] Resident #9- [DATE] Resident #10-[DATE] Resident #11-[DATE] Resident #12 [DATE] Resident #13-[DATE] Resident #14-[DATE] Resident #15-[DATE] Resident #16-[DATE] Resident #17-[DATE] Resident #18-[DATE] Resident #19-[DATE] Resident #20-[DATE] Resident #21-[DATE] Resident #22-[DATE] Resident #23-[DATE] Resident #24-[DATE] Resident #25-[DATE] Resident #26-[DATE] Resident #27-[DATE] Resident #28-[DATE] Resident #29-[DATE] Resident #,[DATE]/!,[DATE] Resident #31-[DATE] Resident #32-[DATE] Resident #33-[DATE] Resident #34-[DATE] Resident #35-[DATE] Resident #36-[DATE] Resident #37-[DATE] Resident #38-[DATE] Resident #39-[DATE] Resident #40-[DATE] Resident #41-[DATE] Resident #42-[DATE] Resident #43-[DATE] Resident #44-[DATE] Resident #45-[DATE] Resident #46-[DATE] Resident #47-[DATE] Resident #48-[DATE] Resident #49-[DATE] Resident #50 [DATE] Resident #51-[DATE] Resident #52-[DATE] Resident #53-[DATE] Resident #54-[DATE] Resident #8 and Resident #25 expired at the facility. Resident #9, Resident #14, Resident #15, and Resident #23 expired at the hospital. Resident #3, Resident #7, Resident #10, Resident #11, Resident #12, Resident #22, Resident #26 and Resident #53 were discharged from facility to Hospice care. Further review of Oakbrook COVID Testing Board documented the facility received positive COVID-19 results for staff as follows: CNA #1(Certified Nursing Assistant) -[DATE] CNA #2-[DATE] CNA #3-[DATE] CNA #4-[DATE] Nurse #1-[DATE] Nurse #2-[DATE] Maintenance-[DATE] Housekeeping #1-[DATE] CNA #6-[DATE] CNA #7-,[DATE]//2020 ADON (Assistant Director of Nursing)-[DATE] Housekeeping #2-[DATE] Nurse #3-[DATE] Housekeeping #3-[DATE] CNA #8-[DATE] Nurse #4-[DATE] A tour of the facility on [DATE] a 10:30 a.m. revealed a thick plastic barrier toward the end of the 100 Hall, which contained rooms 109 through 114. The Director of Nursing (DON) stated behind the plastic barrier were four (4) isolation rooms for the current four (4) active COVID-19 cases in the facility (Residents #33, Resident #50, Resident #51 and Resident #52). The DON further stated during the height of the outbreak, the facility had 25 beds for isolation for COVID-19 positive residents. The DON further revealed through interview on [DATE] at 1:10 p.m. Resident #1 was sent out for a medical appointment on [DATE] to be evaluated for a feeding tube due to not eating well. He/she said the resident was transported via medical transportation service. The DON stated the resident was scheduled to have a feeding tube placed and a COVID-19 test was requested prior to the medical procedure being performed. He/she said the COVID-19 test was performed on [DATE] and was positive and the resident was transferred to a sister facility that had an isolation unit. The DON stated 14 staff that had recently provided care to Resident #1 were tested and seven (7) of the 14 staff tested positive for COVID-19. He/she said the facility did not immediately test the residents that the seven (7) positive COVID-19 staff had recently provided care to, that facility staff monitored the residents and as residents exhibited signs and symptoms of COVID-19, they were then tested . An interview with the facility's Infection Preventionist (IP) on [DATE] at 11:20 a.m. revealed he/she had been unable to work during the peak of the Coronavirus outbreak from [DATE] until [DATE]. He/she said during the COVID-19 outbreak staff monitored residents for signs and symptoms of COVID-19 and would then get orders for testing as indicated. The IP stated he/she was aware of the CDC recommendations dated [DATE]. He/she stated after getting approved polices from corporate office the Infection Control manual would be updated with new policies and procedures, and he/she would provide in-service education for implementation of the new procedures. The IP said he/she did not have the autonomy to update facility policies. A telephone interview with the Nurse Practitioner (NP) on [DATE] at 1:50 p.m. revealed Resident #1 was scheduled to have a feeding tube placed and the Physician had requested a COVID-19 test prior to the procedure. He/she said the resident was tested on [DATE] and was this was the first positive COVID-19 case at the facility. The NP stated Resident #1 could have been exposed to COVID-19 when he/she had been transported by medical transportation service to a medical appointment a week or so before testing positive. He/she said the facility made the decision to not test all residents after Resident #1 and seven (7) staff tested positive for COVID-19. The NP stated the facility monitored residents for signs and symptoms of COVID-19 and he/she wrote orders for tests as signs and symptoms were exhibited by residents. A telephone interview with the Medical Director (MD) on [DATE] at 9:30 a.m. he/she stated the NP kept him/her informed on a daily basis of residents having signs and symptoms and those testing positive for COVID-19. The MD said he/she had conducted telehealth visits with all the residents that had remained in the facility with COVID-19. He/she stated after the facility had the first positive case of COVID-19, residents were monitored and when showing signs and symptoms were tested for COVID-19. The MD said looking at it now, it would have probably been easier to manage the outbreak if all residents had been tested after the initial positive resident case and the seven (7) staff tested positive. He/she said there had been a learning curve for and there was no mandate that all

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) residents were required to be tested after receiving the positive COVID-19 tests (of Resident #1 and the seven (7) staff). An interview with Administrator on [DATE] at 9:10 a.m. revealed after Resident #1 was diagnosed with [REDACTED]. office. He/she stated the facility had a contact person with DHEC and when the facility received a positive COVID-19 test he/she completed a profile and e-mailed it to the contact person at DHEC. The Administrator said the DHEC contact person told him/her on [DATE] to only test residents when they were exhibiting signs and symptoms of COVID-19 and that the state laboratory was back logged. He/she said on [DATE] he/she decided to test the remainder of the residents in the facility that had not been tested . The Administrator stated the facility kept constant communication with their corporate office reporting the number of COVID-19 cases the facility had, and the corporate office would update the facility with new CDC guidelines. The Administrator said the facility had not updated any polices since the COVID-19 outbreak began at the facility. He/she stated all new polices must come from corporate office and must first be reviewed by a legal team and that took time.