STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425379	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OPUS POST ACUTE REHABILITATION	**300 AGAPE DRIVE WEST COLUMBIA, SC 29169**

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, and record review, the facility failed to ensure transmission-based precautions were implemented for two of five sampled residents (Resident #2 and Resident #3). This failure has the potential to negatively affect all residents receiving care in the facility. Findings include: Observations conducted on 06/09/2020 at 11:00 AM revealed the facility had a unit designated for the isolation of newly admitted residents who were awaiting two negative COVID-19 results. Observations on 06/09/2020 at 11:00 AM included the rooms where Resident #2 and Resident #3 were residing in the designated unit in the facility. The observations revealed no indication that Resident #2 and Resident #3 were on transmission-based precautions. Transmission-based precautions include contact and droplet precautions. Contact precautions require the use of Personal Protective Equipment (PPE) of gloves and gowns while providing care. Droplet precautions require the use of PPE of gloves, gowns, and a mask or respirator when providing care. Use and disposal of the proper PPE helps prevent the spread of infection. On 06/09/2020 at 4:39 PM, an interview was conducted with Licensed Practical Nurse (LPN) #7. LPN #7 stated that residents who were placed on transmission-based precautions have PPE and signs posted outside their room doors to alert staff to don PPE prior to entering the resident's room. On 06/09/2020 at 4:42 PM, an interview was conducted with the Registered Dietician (RD). The RD stated that s/he had been trained on the proper use of PPE and would know to utilize PPE by the posting of signs on the residents' doors and PPE being available outside the room. Observations on 06/09/2020 at 11:00 AM revealed no PPE or signage posted outside the doors of Resident #2's and Resident #3's rooms. 1. A review of the electronic health record (EHR) revealed Resident #2 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Admission documents found in the EHR revealed Resident #2 had a negative COVID19 test on 06/05/2020 at the hospital prior to admission to the facility. Review of the EHR physician orders [REDACTED].#2's admission. Further review of the EHR revealed results from a second COVID19 test, administered on 06/08/2020, had not been received by the facility as of 6:00 PM on 06/09/2020. In a follow-up interview conducted on 06/09/2020 at 6:30 PM, the Administrator stated the results of Resident #2's second COVID19 test was received by the facility on 06/09/2020 at approximately 6:15 PM. The Administrator stated that the result of Resident #2's second test was negative for COVID19. 2. A review of the EHR revealed Resident #3 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. The EHR for Resident #3 indicated the resident received a COVID19 test on 06/02/2020 at 12:48 PM at the hospital prior to admission and a second COVID19 test was administered on 06/03/2020 at 11:30 AM (approximately 22 hours and 42 minutes between testing). A review of the physician orders [REDACTED].#3 was placed on transmission-based precautions at the time of admission and was removed from transmission-based precautions on 06/04/2020 based on the negative results of the second COVID19 test. On 06/09/2020 at 12:45 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that s/he was responsible for the infection prevention and control program of the facility and that transmission-based precautions were implemented for all newly admitted residents. The DON stated that the facility used a test-based strategy for discontinuing the use of transmission-based precautions. The DON further stated that once a newly admitted resident received two negative COVID19 tests, transmission-based precautions were discontinued. Once transmission-based precautions were discontinued then the requirement to use PPE, specifically gowns and respirators, when caring for the resident is discontinued. However, the DON did not provide an explanation for why Resident #2 did not have an order to be placed on transmission-based precautions at the time of the resident's admission to the facility. During a follow-up interview with the DON on 06/09/2020 at 2:25 PM, the DON confirmed that Resident #2 never received an order to be placed on transmission-based precautions at the time of admission to the facility. In addition, the DON confirmed that Resident #3 was taken off of transmission-based precautions on 06/04/2020 based on the test results of the resident's second COVID19 test done on 06/03/2020. The DON confirmed that Resident #3's second test was collected before the required 24-hour time period between each COVID19 test was reached. On 06/09/2020 at 2:40 PM, an interview was conducted with the facility Administrator. The Administrator stated that the facility required two confirmed negative COVID19 tests for newly admitted residents before discontinuing the use of transmission-based precautions and the use of PPE while providing care. In addition, the Administrator stated that he was not aware Resident #2 did not have an order for [REDACTED].#3's second COVID19 test was collected prior to the required 24-hour time period between each COVID19 test. Review of facility policy titled, Emerging Infectious Disease (EID): Coronavirus Disease 2019 (COVID-19), revised 04/08/2020, stated that the facility will ensure facility policies and practices are in place to minimize exposures to respiratory pathogens including [DIAGNOSES REDACTED]-COV-2, [MEDICAL CONDITION] that causes COVID19. Measures should be implemented before patient arrival, upon arrival, throughout the duration of the patient's visit, and until the patient's room is cleaned and disinfected. The policy further indicated that newly admitted residents were to be isolated in private rooms for 14 days and transmission-based precautions would be implemented. In addition, the policy indicated the facility will, adhere to Standard and Transmission-Based Precautions. The policy further stated that the decision to discontinue Transmission Based Precautions should be made using a test-based strategy (two negative tests) or a non-test-based strategy (i.e., time-since-illness-onset and time since recovery strategy) . The policy also refers to the guidance provided by the Centers for Disease Control (CDC) requiring a second COVID19 test to be completed by the facility, equal to or greater than 24 hours after the first COVID19 test.

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.