| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 425132 | A. BUILDING _____ B. WING _____ | 08/03/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| RIDGELAND NURSING CENTER INC | 1516 GRAYS HIGHWAY RIDGELAND, SC 29936 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 interviews, record review, and review of the facility's policies, the facility failed to prevent the potential transmission of the coronavirus (COVID-19) from the community into the facility for 21 out of 26 residents who resided on wing B (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20 and #21). The facility failed to follow their COVID-19 Prevention and Response policy; they did not place Resident #4 in isolation for 14 days upon his/her return from leave of absence (LOA) on 6/23/2020; Resident #4 was placed in the general population, wing B, sharing a room with one other resident. Resident #4 exhibited symptoms of COVID-19 on 6/27/2020, four (4) days after returning from LOA. Resident #4 was sent to the emergency roiagnom on [DATE] and was confirmed positive for COVID-19 on 7/1/2020. This resulted in a COVID-19 outbreak in which 20 residents, on wing B, exhibited symptoms of COVID-19 and were confirmed positive for COVID-19 after Resident #4. The findings include: Review of the CMS (Centers for Medicare & Medicaid Services) COVID-19 Long-Term Care Facility Guidance at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, updated 6/25/20, revealed long-term care facilities should create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (Healthcare Personnel) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves and gown when caring for these residents. Residents can be transferred out of the observation areas to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. Have a plan for how roommates, other residents, and HCP who may have been exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them). Review of the facility's policy titled Pandemic Coronavirus (COVID-19) Prevention and Response, undated, revealed residents who were new admissions/returns would be screened for a detailed travel history, possible exposure of any signs/symptoms of respiratory illness; new admissions/returns must agree to be placed in isolation for 14 days, as appropriate; and new admissions/returns may be cohorted, per isolation policy as appropriate. Review of the census dated 6/23/2020 revealed 26 residents resided on wing B. Review of Resident #4's clinical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Continued review of the resident's record revealed the resident resided in room [ROOM NUMBER] on wing B; the room was shared with one other resident, Resident #22. There was no reference for quarantine or transmission-based precautions for Resident #4 in the record to prevent a potential transmission of COVID-19 when the resident returned from the LOA. Review of the Release of Responsibility for Leave of Absence form dated 6/23/2020, revealed Resident #4 was released from the facility at 12:45 p.m. Review of Resident #4's nurses' progress note, dated 6/23/2020 at 7:30 p.m., revealed Resident returned from family funeral with no acute distress noted. No c/o (complaint of) pain. Afebrile. Bed in lowest position. Call bell within reach. Review of the Resident #4's Nurse's Progress Note, dated 6/27/2020, revealed, resident with elevated temperature 100.3 and complained of headache and abdominal pain. MD notified, stated to send resident out to ER (emergency room ) for further evaluation due to elevated temp and c/o headache and abdominal pain. Review of Resident #4's Progress Note dated 7/3/2020 revealed the resident's Physician was called related to patient returning from the hospital. The Physician was made aware of [DIAGNOSES REDACTED]. Review of Resident #4's Progress Note dated 7/3/2020 revealed patient is in isolation and being monitored due to [DIAGNOSES REDACTED]. Resident #1's earliest onset of COVID-19 was 7/13/2020 and [MEDICAL CONDITION] was detected on 7/13/2020. 2. Resident #2's earliest onset of COVID-19 was 7/20/2020 and [MEDICAL CONDITION] was detected on 7/20/2020. 3. Resident #3's earliest onset of COVID-19 was 7/19/2020 and [MEDICAL CONDITION] was detected on 7/19/2020. 4. Resident #4's earliest onset of COVID-19 was 6/27/2020 and [MEDICAL CONDITION] was detected on 7/1/2020. 5. Resident #5's earliest onset of COVID-19 was 7/2/2020 and [MEDICAL CONDITION] was detected on 7/2/2020. 6. Resident #6's earliest onset of COVID-19 was 7/4/2020 and [MEDICAL CONDITION] was detected on 7/4/2020. 7. Resident #7's earliest onset of COVID-19 was 7/5/2020 and [MEDICAL CONDITION] was detected on 7/5/2020. 8. Resident #8's earliest onset of COVID-19 was 7/5/2020 and [MEDICAL CONDITION] was detected on 7/5/2020. 9. Resident #9's earliest onset of COVID-19 was 7/11/2020 and [MEDICAL CONDITION] was detected on 7/9/2020. 10. Resident #10's earliest onset of COVID-19 was 7/11/2020 and [MEDICAL CONDITION] was detected on 7/9/2020. 11. Resident #11's earliest onset of COVID-19 was 7/11/2020 and [MEDICAL CONDITION] was detected on 7/9/2020. 12. Resident #12's earliest onset of COVID-19 was 7/11/2020 and [MEDICAL CONDITION] was detected on 7/9/2020. 13. Resident #13's earliest onset of COVID-19 was 7/12/2020 and [MEDICAL CONDITION] was detected on 7/9/2020. 14. Resident #14's earliest onset of COVID-19 was 7/12/2020 and [MEDICAL CONDITION] was detected on 7/9/2020. 15. Resident #15's earliest onset of COVID-19 was 7/12/2020 and [MEDICAL CONDITION] was detected on 7/9/2020. 16. Resident #16's earliest onset of COVID-19 was 7/12/2020 and [MEDICAL CONDITION] was detected on 7/12/2020. 17. Resident #17's earliest onset of COVID-19 was 7/19/2020 and [MEDICAL CONDITION] was detected on 7/19/2020. 18. Resident #18's earliest onset of COVID-19 was 7/21/2020 and [MEDICAL CONDITION] was detected on 7/21/2020. 19. Resident #19's earliest onset of COVID-19 was 7/24/2020 and [MEDICAL CONDITION] was detected on 7/23/2020. 20. Resident #20's earliest onset of COVID-19 was 7/24/2020 and [MEDICAL CONDITION] was detected on 7/23/2020. 21. Resident #21's earliest onset of COVID-19 was 7/25/2020 and [MEDICAL CONDITION] was detected on 7/23/2020. Interview on 8/3/2020 at 5:38 p.m. with Resident #4's family member, revealed Resident #4's child picked him/her up on 6/23/2020 at 12:45 p.m., and took him/her to the funeral of his/her sibling. Resident #4 wore a face mask during the funeral services; however, Resident #4 ate lunch with approximately 20 family members and neither the resident nor the family members wore face masks. Interview on 8/3/2020 at 4:05 p.m. with the Treatment Nurse revealed Resident #4 was placed into his/her room with his/her roommate, Resident #22, on 6/23/2020 after leaving the facility for a few hours to attend a funeral. Continued interview revealed the facility did not consider Resident #4 as a resident return to the facility. The Treatment Nurse stated she was not aware of a policy indicating that when residents went out of the facility, the facility must place them in isolation 14 days. The Treatment Nurse stated Resident #4 wasn't exhibiting signs of COVID-19. The Treatment Nurse stated Resident #4 was sent out to the emergency room due to exhibiting symptoms of the coronavirus on 6/27/2020. The Treatment Nurse also stated the hospital notified the facility that Resident #4's COVID-19 test result was positive on 7/1/2020. Interview with the Infection Preventionist on 8/3/2020 at 6:07 p.m. revealed the facility's coronavirus policy stated new admissions and returns should be placed on droplet precautions for 14 days. The Infection Preventionist also stated that returns was defined as any resident that was admitted to the facility then left the facility and returned to the facility. The Infection Preventionist stated Resident #4 should have been placed in a private room for 14 days after the LOA and monitored for signs and symptoms of COVID-19. Interview on 8/3/2020 at 4:29 p.m. with the Administrator revealed the facility did not have a policy for placement of residents that took a leave of absence; however, the facility's policy was to place readmissions and new admissions on droplet precautions in a private room. The Administrator stated residents that left the facility to visit family was not considered a readmission to the facility. The |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>Administrator stated the facility didn't need to place the resident on isolation because she/he didn't have any signs and symptoms. The Administrator stated he/she made the decision to let Resident #4 leave the facility and that he/she couldn't keep the residents in the building if they wanted to leave. Interview on 8/3/2020 at 4:55 p.m. with the Medical Director revealed the facility policy was no visitors and no leave of absence should be granted to residents. He/she was notified that Resident #4 left the facility to go to the funeral after it happened. He/she expected staff to isolate the resident for 14 days and monitor each shift for signs and symptoms of [MEDICAL CONDITION] upon return to the facility. |