STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425080	A. BUILDING _____ B. WING _____	**06/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KERSHAWHEALTH KARESH LONG TERM CARE	**1315 ROBERTS STREET CAMDEN, SC 29020**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of the facility's policies and procedures, the facility failed to ensure proper infection prevention and control procedures were followed for cleaning therapy equipment used with one of five sampled residents (Resident #1) who was on transmission-based precautions and two of five residents (Resident #2 and Resident #3) who were on standard precautions. On 06/10/2020, a Certified Occupational Therapy Assistant (COTA) was observed exiting Resident #1's room with equipment used to provide therapy services. The COTA was observed cleaning the equipment prior to taking off the disposable gloves s/he wore while providing care to Resident #1. This failure had the potential to negatively affect eight other residents receiving therapy services provided by the COTA on 06/10/2020. Findings include: On 06/10/2020 from 10:32 AM- 11:01AM, the COTA was observed in Resident #1's room providing therapy services while wearing Personal Protective Equipment (PPE), that included a disposable gown, disposable gloves, a facemask, and a face shield. At 11:02 AM, the COTA was observed exiting Resident #1's room with a bedside table used to transport therapy equipment. The therapy equipment included two Therap-E bars, one pedal machine, three hand grips, a timer, and two barbells. The COTA was observed cleaning the therapy equipment with a CaviWipe (a hard surface, disinfectant wipe) prior to taking off the disposable gloves she wore while providing care to Resident #1. After cleaning the therapy equipment found on the bedside table, the COTA took off her/his disposable gown and disposable gloves, performed hand hygiene, then removed her/his face shield and cleaned the face shield with a CaviWipe and placed it on the bedside table. During a interview on 06/10/2020 at 11:03 AM, the COTA stated s/he used the therapy equipment on the bedside table to provide services to multiple residents in the facility and only cleaned the equipment after using the equipment with each resident. In addition, COTA did not know the dry time for the CaviWipes used to clean the equipment. A review of Resident #1's medical record revealed the resident was admitted to the facility on [DATE] and was placed in a private room for 14 days of isolation. Further review of Resident #1's physicians orders in the medical record revealed the resident had an order to be placed on Tier 2 transmission-based precautions, to include contact and droplet precautions. These precautions require facility staff to wear a gown, gloves, and face mask while providing care to the resident. On 06/10/2020 at 12:48 PM, the Director of Therapy Services (DTS) stated s/he expected therapy services staff members to clean and sanitize equipment before and after the equipment is used to provide services to residents in the facility. In addition, the DTS stated all therapy services staff members have been trained on proper use of PPE and the COTA should have changed her disposable gloves prior to cleaning the equipment. The DTS further indicated the COTA had eight residents on her caseload for 06/10/2020. However, the DTS could not confirm if any of the other residents receiving services from the COTA were potentially exposed to the therapy equipment prior to the equipment being properly disinfected or replaced. On 06/10/ 0 at 1:37 PM, the COTA was observed in Resident #2's room performing bedside therapy with the same therapy equipment on a bedside table. At 1:51 PM, the COTA was observed cleaning the equipment with the CaviWipes. At 1:55 PM, the COTA was observed entering Resident #3's room with the table tray and therapy equipment without cleaning it prior to entering the room to provide therapy services to Resident #3. The observation also revealed one hand grip with broken plastic coating and one dumbbell with broken plastic coating, creating an uncleanable surface on the equipment. Review of Resident #2's medical record revealed Resident #2 was admitted to the facility on [DATE] for therapy after a femur fracture. Further review revealed Resident #2 was not on isolation precautions and did not have any signs and/or symptoms of infection. Review of Resident #3's medical record revealed Resident #3 was admitted to the facility on [DATE] for therapy related to the repair of a right [MEDICAL CONDITION]. In addition, the review revealed the resident was not on any isolation precautions and had no signs and/or symptoms of any infection. On 06/10/2020 at 1:45 PM, the Infection Control Nurse (ICN) stated equipment used to provide care to residents should be cleaned before and after use. In addition, the ICN stated the COTA should have changed her/his gloves prior to cleaning the equipment and any equipment with broken plastic coatings should be replaced to ensure equipment does not have uncleanable surfaces. On 06/10/2020 at 2:00PM, the Director of Nursing (DON). stated s/he expected all facility staff to follow proper infection control practices and acknowledged the COTA should have changed her/his gloves prior to cleaning the therapy equipment used to provide services to Resident #1. On 06/10/2020 at 2:20 PM, the Administrator stated all staff have been trained on the proper use of PPE and the infection control practices of the facility. The Administrator further stated the facility would replace the therapy equipment with uncleanable surfaces and acknowledged the COTA should have used clean gloves to clean equipment used to provide care to residents at the facility. Review of the facility policy's titled, Infection Control, dated revised 11/30/2017, stated, Change gloves between tasks and procedures on the same resident. In addition, the policy required, Used equipment will be cleaned/disinfected after use when a resident is in isolation precautions. In addition, the facility's policy stated the appropriate device handling patient care equipment included staff should ensure that reusable equipment is not used for the care of another patient until it has been appropriately cleaned.

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