STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425155	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LANCASTER CONVALESCENT CENTER	2044 PAGELAND HWY LANCASTER, SC 29720

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review, review of training records and review of facility policies, the facility failed to ensure that required transmission-based precautions were implemented to prevent the spread of Coronavirus (COVID)-19 on three (3) of five (5) facility halls where three (3) of five (5) contracted housekeeping (HK) staff (HK #2, HK #3 and HK #5) failed to adhere to the Environmental Protection Agency (EPA)-registered disinfectant contact-time instructions when cleaning residents' rooms. The facility also failed to ensure appropriate transmission-based precautions were implemented for two (2) of four (4) sampled residents (Resident #1 and Resident #4) and for one (1) non-sampled resident who were ordered transmission-based precautions to prevent the spread of suspected COVID-19. A Targeted Infection Control Survey was conducted at Lancaster Convalescent Center on June 23-24, 2020. During the survey, the facility was determined not to be in substantial compliance, as evidenced by: On 6/23/2020, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's Director of Nursing (DON) was informed of the immediate jeopardy on 6/23/2020 at 4:20 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on 5/30/2020. The immediate jeopardy continued through 6/24/2020 and was removed on 6/24/2020 at 11:26 a.m. when the facility implemented a Credible Allegation of Compliance. An IJ remvoal plan was provided and accepted by the SA on 6/24/20. The removal plan was validated and the immediacy of the deficient practice was removed on 6/24/2020 dropping the S/S to E. The immediate jeopardy is outlined as follows: 1. Three (3) of five (5) HK staff (HK #2, HK #3 and HK #5) on facility halls 100, 200 and 300 failed to adhere to the contact-time specified by the Environmental Protection Agency registered disinfectants used to clean and disinfect residents' rooms, including rooms on halls 100, 200 and 300 that required transmission-based precautions for residents suspected positive for COVID-19. The contact-time was the amount of time required for the chemical to remain on the environmental surface being cleaned, in order to breakdown all membranes that surround bacteria [MEDICAL CONDITION]. In addition, HK #2 used a bottled labeled as glass cleaner to clean/disinfect environmental surfaces in residents' rooms. Facility staff were not able to identify the chemical inside the bottle. 2. Facility staff failed to ensure Resident #1's door remained closed while the resident and roommate were under transmission-based precautions for suspected COVID-19. 3. The facility's contracted Nurse Practitioner (NP) failed to don gloves, gown and a face shield when entering a non-sampled resident's room; the resident was on transmission-based precautions for suspected COVID-19. 4. The facility's contracted [MEDICAL TREATMENT] transport staff failed to apply the required personal protective equipment (PPE) when transporting Resident #4 back into his/her room; Resident #4 was on transmission-based precautions for suspected COVID-19. It was determined the above multiple failures placed residents at risk for the likelihood of serious harm, injury or death, by facility staff not adhering to required transmission-based precautions to prevent the spread of COVID-19. The findings included: Interview on 6/23/2020 at 9:30 a.m. with the facility's Director of Nursing (DON) revealed the facility's first case of a resident testing positive for COVID-19 was on 5/30/2020. At the time of the interview, the facility had eight (8) residents positive for COVID-19 (which was down from 27 residents having tested positive for COVID-19, as 19 had been cleared). At the time of the interview, there were 25 residents in the facility who were suspected positive and awaiting test results for COVID-19. 1. Review of the facility's Coronavirus Disease 2019 (COVID-19) Pandemic Prevention and Response Plan dated 3/16/2020 revealed Environmental Services facilitates daily cleaning of all frequently touched surfaces, such as bedrails, over-bed tables, night-stands, door-knobs, handrails, equipment, etc. Review of the facility's Infection Prevention and Control Policies and Procedures: Subject: Coronavirus Disease 2019 (COVID-19), undated, noted Environmental Cleaning and Disinfection: A. Routine cleaning and disinfection procedures are appropriate for [DIAGNOSES REDACTED]-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus 2), including those patient/resident care areas in which aerosol-generating procedures are performed; and B. EPA-registered hospital-grade disinfectants with an emerging [MEDICAL CONDITION] pathogen are recommended to use against [DIAGNOSES REDACTED]-CoV-2. Review of Quality Control Inspection - Housekeeping completed on 6/16/2020 and 6/17/2020 by the facility's contracted Director of Housekeeping (DOH) revealed Housekeeper (HK) #2 was observed by the DOH and the following was noted: unsatisfactory cleaning of ceiling/walls, windowsill/blinds, heating unit, closet/shelf, bedside table, chairs and waste baskets. The DOH noted on 6/16/2020 - Dusty, window spider web and on 6/17/2020 - Dusty, chair needs cleaning. Review of Quality Control Inspection - Housekeeping completed on 6/8/2020, 6/9/2020, and 6/10/2020 by the facility's contracted DOH revealed HK #3 was observed by the DOH and the following was noted: unsatisfactory cleaning of ceiling/walls, windowsill/blinds, lights/switches, TV/light/table, baseboard/edges, waste baskets, light/mirror and sink/ fixtures. The DOH noted on 6/8/2020 - Stain on wall, stain in trash can. Dusty windowsill, blinds, baseboard edges dusty; on 6/9/2020 - Stain on wall, light dusty, fixture dusty, trash can; and on 6/10/2020 - Wall poop stain, baseboard dusty windowsill dusty. Review of Quality Control Inspection - Housekeeping completed on 6/1/2020, 6/2/2020, and 6/4/2020 by the facility's contracted DOH revealed HK #5 was observed by the DOH and the following was noted: unsatisfactory cleaning of heating unit, TV/light/table, floors, and toilet. The DOH noted on 6/1/2020 - Dusty unit, TV dusty, trash on floor; on 6/2/2020 - Trash on floor, toilet stained; and on 6/4/2020 - toilet stained. Review of the contracted Housekeeping staff's training record revealed HK #2, HK #3 and HK #5 received the following education: 3/10/2020 - EVS (Environmental Services) Chemical Use, Dilution and Hazards Inservice Quiz. 5/26/2020 - COVID - Disinfection of Clothes Hangers in Facilities where COVID-19 is/was Present. 5/26/2020 - COVID - Interim Recommendation for Terminal COVID-19 Isolation Room/Unit Cleaning. Review of information obtained on 6/24/2020 from www.epa.gov (Environmental Protection Agency (EPA) website) noted when disinfecting surfaces, staff must follow the contact time listed on the product's label. The contact time is the amount of time the surface should be visibly wet, in order to breakdown all membranes that surround bacteria [MEDICAL CONDITION]. According to the EPA's website, Virex and AirX disinfectants both have a contact time of 10-minutes. During an interview with the facility's Director of Nursing (DON) on 6/23/2020 at 9:30 a.m., the DON revealed that he/she was also the facility's Infection Preventionist. The DON said housekeeping staff used Virex disinfectant spray to clean residents' rooms. The DON was not sure of the contact-time for the chemical. Observations with the DON present on 6/23/2020 between 10:50 a.m. and 11:35 a.m. revealed the following: the facility's 100 Hall had 18 resident rooms. There were six (6) rooms on the hall with signage indicating transmission-based precautions were required before entering the rooms; the facility's 200 Hall had 18 resident rooms and there were three (3) rooms on the hall with signage indicating transmission-based precautions were required before entering the rooms; and the facility's 300 Hall had 18 resident rooms with four (4) rooms on the hall with signage indicating transmission-based precautions were required before entering the rooms. Interview with the DON at 10:55 a.m. revealed the residents in the transmission-based precaution rooms were suspected to be positive for COVID-19. Observations on 6/23/2020 at 11:00 a.m. revealed HK #2 was with the housekeeping cart outside of room [ROOM NUMBER]. Interview at this time with HK #2 revealed the staff had worked at the facility for five (5) years. HK #2 was asked about the cleaning of residents' rooms and the type of disinfectant used for cleaning. HK #2 stated U1 was the disinfectant used

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) to clean the rooms. When asked if there was a certain time period the disinfectant had to remain on environmental surfaces before it was wiped down, HK #2 said there was no certain amount of time for spray to be on surfaces. When the Surveyor asked to see the bottle of disinfectant used to clean the rooms, HK #2 presented a bottle that was labeled Glance NA - Glass and Multi-Surface Cleaner. HK #2 said the wrong label was on the bottle because the Director of Housekeeping (DOH) did not have labels available to place on the bottle. The housekeeper said that he/she had written U1 on the bottle with a black marker, but the marker had rubbed off. When asked how the housekeeper could be sure of what chemical was in the bottle, HK #2 said he/she had re-filled the bottle at the beginning of the shift. HK #2 said that the chemical in the bottle was used to clean the tables, bedrails, and other surfaces in the residents' rooms. During continued interview with HK #2, the housekeeper said that he/she had received no re-education regarding cleaning and disinfecting rooms since the onset of the COVID-19 pandemic. HK #2 said he/she had already cleaned most of the rooms on the hall. Interview on 6/23/2020 at 11:10 a.m. with the facility's contracted DOH revealed the disinfectants used to clean the residents' rooms were Virex, Comet with Bleach, AirX and U1. The DOH said U1 was not used very often. The DOH said that housekeeping staff filled their disinfectant bottles at the beginning of their shift and all bottles were correctly labeled. The DOH was asked where the U1 disinfectant was stored, and the DOH escorted the Surveyor and DON to a storage closet. After opening the storage closet, the DOH stated that he/she forgot that the U1 disinfectant was not stored in this location. The DOH continued and said that the U1 disinfectant was stored on the COVID-19 unit, and the housekeepers on halls 100, 200, 300 and 400 did not have access to the storage area on the COVID-19 unit. The DOH said HK #2 likely re-filled the bottled with the disinfectant AirX. When asked about the kill-time for the disinfectants, the DOH said that all of the disinfectants used had a kill-time of 10 minutes. The DOH also said that housekeeping staff were monitored daily to ensure the proper cleaning of rooms. Follow-up interview on 6/23/2020 at 11:15 a.m. with HK #2 with the DOH and the DON present revealed that HK #2 repeated that he/she re-filled the bottle with U1 at the beginning of the shift and that U1 was written on the bottle but it came off. The DOH asked HK #2 Where is the plastic sticky label? for the bottle. HK #2 did not respond. When HK #2 was again asked about the amount of time for the disinfectant to remain on the environmental surface before being wiped off, the housekeeper stated there was, no particular time for disinfectant to be used before wiping - I wait about five (5) minutes. HK #2 and the DOH could not confirm what chemical was in the bottle labeled as glass cleaner which was being used to clean residents' rooms on the 200 Hall. During a follow-up interview on 6/23/2020 at 11:17 a.m. with the DON, the nurse stated that if HK #2 did not allow the disinfectant to remain on the surface for the required contact time before wiping off environmental surfaces in residents' rooms, then residents' rooms were not being properly cleaned and disinfected, which increased the potential to spread COVID-19. The DON stated that HK #2 regularly cleaned the rooms on the 200 Hall. Interview on 6/23/2020 at 11:22 a.m. with HK #3 revealed the housekeeper had worked in the position for [AGE] years. HK #3 had cleaned all of the rooms on 100 Hall except for the transmission-based precaution rooms. HK #3 presented a bottle labeled AirX and stated it was the disinfectant used to clean residents' rooms. When asked if there was a certain amount of time the disinfectant spray had to remain on a surface before being wiped off, HK #3 said that he/she sprayed it on and wiped it off. The housekeeper continued and said he/she was never informed that the chemical needed to be left on for a period of time before being wiped off. HK #3 said that residents' rooms were being cleaned the same as before the onset of the COVID-19 pandemic. The housekeeper worked four (4) days per week at the facility. Interview on 6/23/2020 at 11:40 a.m. with HK #5 revealed the staff had the position at the facility for six (6) years. The housekeeper presented a bottle of AirX to the Surveyor when asked about the disinfectant used to clean residents' rooms. HK #5 said he/she sprayed the surfaces in residents' rooms with the disinfectant and then waited approximately 30 seconds before wiping the surface down. HK #5 said he/she had never been told to wait to wipe it down. HK #5 said he/she had already cleaned all rooms on 300 Hall. HK #5 worked regularly on the 300 Hall. Interview on 6/23/2020 at 4:30 p.m. with the facility's DON revealed that the contracted Housekeeping company's Regional Housekeeper informed the DON that U1 had been discontinued and AirX was now in use, and the disinfectant had a contact time of 10 minutes. 2. Review of information obtained from www.cdc.gov on 6/24/2020 noted properly manage anyone with symptoms of COVID-19 or who has been advised to self-quarantine .patients should be isolated (in room) with the door closed. Review of the facility's Coronavirus Disease 2019 (COVID-19) Pandemic Prevention and Response Plan dated 3/16/2020 revealed the Infection Preventionist was responsible for ensuring implementation of appropriate infection control measures/precautions and isolation in accordance with CDC, state/local health department recommendations. Review of Resident #1's clinical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's COVID-19 suspected/possible exposure care plan initiated 6/13/2020, revealed transmission-based precautions for COVID-19 were initiated on 6/13/2020. Observation on 6/23/2020 between 11:50 a.m. and 12:10 p.m. revealed there was a Special Precautions sign outside of Resident #1's door, indicating the Resident(s) inside the room were suspected to be positive for COVID-19. The sign noted Everyone must clean hands when entering and leaving room. Gown, gloves, N-95 and eye protection (must be used). Keep door closed. Use patient dedicated or disposable equipment. Clean and disinfect shared equipment. There was also a PPE cart outside of the room. Resident #1's room door was ajar. Resident #1 was not in the room; however, Resident #1's roommate was lying in a supine position with the head of the bed slightly elevated. The door from the hallway into the room (room door) was observed to be open for twenty-minutes and the Surveyor did not observe any staff member close the door during this period of time. Interview on 6/23/2020 at 11:58 a.m. with Resident #1's Unit Manager (UM) revealed that Resident #1 was currently at his/her [MEDICAL TREATMENT] appointment. The UM confirmed that Resident #1 and his/her roommate were on transmission-based precautions for suspected cases of positive COVID-19. The UM said that Resident #1 and the roommate had both been swabbed for the COVID-19 lab test and both residents in the room were on transmission-based precautions. When asked about the required PPE and whether Special Precaution rooms doors should be opened or closed, the UM stated the door (was) to be closed at all times. Observations after the interview between 11:59 and 12:10 p.m. revealed Resident #1's room door remained opened. During an interview on 6/24/2020 at 4:30 p.m. with the facility's DON, the nurse confirmed that Resident #1's room door should have been closed due to the resident's transmission-based precautions. 3. Review of information obtained from www.cdc.gov on 6/24/2020 noted Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown .Because of higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP (healthcare providers) is newly identified in the facility . Review of the facility's Coronavirus Disease 2019 (COVID-19) Pandemic Prevention and Response Plan dated 3/16/2020 revealed the Infection Preventionist was responsible for ensuring implementation of appropriate infection control measures/precautions and isolation in accordance with CDC, state/local health department recommendations. Observations on 6/23/2020 at 12:11 p.m. on 100 Hall of the facility revealed that the Nurse Practitioner (NP) entered room [ROOM NUMBER]. room [ROOM NUMBER] had a Special Precautions notice on the door and a cart for personal protective equipment (PPE) outside of the room, indicating the resident was on transmission-based precautions and suspected of being COVID-19 positive. The NP was wearing an N-95 mask; however, the NP was wearing no other required PPE. The NP did not don gloves, gown, or face shield before entering the Resident's room. The non-sampled resident was inside the room sitting in a manual wheelchair. The NP stepped approximately two (2) feet inside the room and stood within three (3) feet of the Resident. The NP had a conversation with the resident for approximately one (1) minute and then exited the room. After exiting the room, the NP went directly to the medication cart and used hand sanitizer to clean his/her hands. The NP then walked over to a non-sampled Resident who was sitting across from the nurses' station and stood within less than one (1) foot of the Resident and had a conversation with the Resident for approximately two (2) minutes. Interview with the DON on 6/23/2020 at 12:12 p.m. confirmed the NP was inside the non-sampled Resident's room [ROOM NUMBER] without the required PPE. During an interview on 6/23/2020 at 12: 28 p.m. with the contracted NP, the NP stated he/she didn't realize and thought the resident in room [ROOM NUMBER] was under contact precautions. The NP confirmed that he/she did not use contact precaution when he/she entered the resident's room. The NP confirmed he/she entered the resident's room without using the required PPE. The NP stated, that he/she was in the wrong there. 4. Review of information obtained from www.cdc.gov on 6/24/2020 revealed for newly admitted residents into the facility, Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if respirator is not available), eye protection (i.e. goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Review of Resident #4's clinical record revealed an admission date of [DATE] with an admitting primary [DIAGNOSES REDACTED]. Continued review of the record revealed a physician's orders [REDACTED]. Review of Resident #4's Baseline Care Plan dated

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) 6/15/2020 revealed the facility implemented COVID-19 transmission-based precautions for the newly admitted resident. Observation on 6/23/2020 at 12:20 p.m. revealed two (2) [MEDICAL TREATMENT] transport staff brought Resident #4 back to his/her room. On the outside of Resident #4's room was a sign that read Special Precautions, indicating Resident #4 was on transmission-based precautions for suspected COVID-19. Both [MEDICAL TREATMENT] transport staff were wearing face masks and gloves as they transported Resident #4 into his/her room. The transport staff were not wearing other required PPE (gown and face shield or goggles) as they were transporting Resident #4. During an interview on 6/23/2020 at 9:30 a.m. with the DON, the nurse stated that [MEDICAL TREATMENT] transport staff wore the required PPE when transporting residents with confirmed or suspected COVID-19 to their [MEDICAL TREATMENT] appointments. The DON stated the [MEDICAL TREATMENT] transport staff wore a jumpsuit, along with gloves, goggles and facemask when transporting residents confirmed with COVID-19. The DON said the same process was to be used for residents who were suspected positive for [MEDICAL CONDITION]. Follow-up interview on 6/23/2020 at 12:30 p.m. with the facility's DON confirmed that the [MEDICAL TREATMENT] transport staff should have been wearing all required PPE when transporting Resident #4 back from his/her [MEDICAL TREATMENT] appointment.