| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 425416 | A. BUILDING _____ B. WING _____ | 06/27/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| SENIOR CARE OF MARION | 2770 S HIGHWAY 501 MARION, SC 29571 |

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) |
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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 observations, record reviews and staff interviews, the facility failed to maintain infection control practices as evidenced by not wearing a face cover properly for 3 of 15 staff observed (Private Sitter, Housekeeper #1 and Registered Nurse (RN) #1; failed to prevent 1 of 15 employees (Certified Nursing Assistant (CNA) #2) from being in the facility with an elevated temperature; and failed to post a contact precautions sign and don full personal protective equipment (PPE) before entering the room of 1 of 3 residents (Resident #1). These failures occurred during the COVID-19 pandemic and had the potential to affect all residents. The findings included: 1. During an interview with Housekeeper #1 on 06/27/20 at approximately 2:00 PM, an observation was made of his/her surgical mask loosely fitting, exposing his/her nostrils and lips on several occasions. Housekeeper #1 was asked about the loose fit and stated that the facility had provided a head band to help tighten the ear loops, but s/he had asthma so had trouble breathing with the mask on. S/he went on to say that s/he doesn't allow it to hang low when s/he was around the residents. It was then pointed out that s/he allowed the mask to hang low, exposing his/her mouth and nose during our conversation and that it was not being worn properly. RN #1 was interviewed on 06/27/20 at approximately 3:25 PM, s/he was observed wearing a surgical mask across his/her face and the metal clip was not pinched across the bridge of his/her nose. During our conversation, his/her mask exposed his/her nostrils a few times while s/he spoke. When asked if his/her mask was too loose, s/he mentioned that if s/he bent it across his/her bridge, the mask would fit too close to his/her eyes. During an observation of Private Sitter #1 for Resident #2 on 06/27/20 at 3:39 PM, s/he was seated in his/her room, approximately 8 feet from the unmasked resident in bed. S/he shared that when s/he worked in the facility, s/he must be screened by staff and given a surgical mask to wear. Private Sitter #1 had removed his/her surgical mask and had it suspended from his/her right ear lobe. The Administrator was interviewed on 06/27/20 at approximately 4:00 PM, regarding the requirement to wear face cover. S/he shared that anyone entering the building must have a face cover in place and the facility provided surgical masks for anyone entering the building. The Administrator relayed s/he must constantly monitor that staff wear face masks and s/he had previously counseled Housekeeper #1 about wearing his/her mask properly and had demonstrated to them how s/he could take deep breaths while still keeping the masks in place, if s/he was having discomfort breathing. A review of the Centers for Disease Control's guidelines, Preparing for COVID-19 in Nursing Homes, last updated on 6/25/20, indicated, Implement Source Control Measures. HCP (Healthcare Personnel) should wear a facemask at all times while they are in the facility. 2. The facility maintained a Visitor and Staff Sign In Sheet - Monitoring for Coronavirus at the receptionist desk at the entrance of the facility. The desk was manned by the receptionist upon surveyor arrival at 12:30 PM, who took the surveyor's temperature using a temporal thermometer. The sign in sheet was reviewed and indicated that CNA #2 had recorded a temperature of 100.4 degrees Fahrenheit (F) on 06/27/20. On the sheet, questions were asked if the staff or visitor had shortness of breath, a cough or respiratory issues. CNA #2 had answered that s/he was not experiencing any of those symptoms. At the end of the sheet was a column to indicate that the Director of Nursing (DON) had completed an audit and was supposed to initial next to the verified entries. There were no marks on the sheet, noting if the DON had verified CNA #2's elevated temperature. The receptionist was interviewed on 06/27/20 at 3:35 PM and s/he shared that s/he worked at the desk from 8:00 AM to 8:00 PM. S/he recorded temperatures most of the times but acknowledged that some staff recorded their own temperature and filled out the sign in sheet. S/he did not record the temperature for CNA #2, earlier that day. During an interview with the Administrator on 06/27/20 at approximately 4:00 PM, s/he stated CNA #2 had attended a training at the facility earlier that day and was not currently on duty. When asked if CNA #2 should have been excluded from the training based on her elevated temperature, s/he deferred the question to the DON. CNA #2 was interviewed on 06/27/20 at approximately 4:15 PM when s/he arrived at work for the 3:00 PM -11:00 PM shift. S/he acknowledged that s/he took her own temperature because the receptionist was away from their desk and the other staff who normally sat nearby were away from their desk, getting ready for training. CNA #2 commented that if a temperature was over 100.0 degrees F, the staff was not supposed to stay at work without first taking more temperatures to check the accuracy. S/he was unable to find the 2nd temporal thermometer and did not go on the floor to retrieve an oral thermometer to check it. S/he mentioned that s/he had driven to work without using the air conditioner and felt that it had caused hs/her body to be warm. Also, the day before s/he got stung by a bee on his/her forehead and thought it might be responsible for the raised temperature. Further, CNA #2 stated that because s/he didn't have other symptoms, s/he went ahead and joined a class of nearly 25 employees for training that lasted an hour. During the training, CNA #2 stated s/he informed the DON of his/her temperature and was told that it would be re-checked. When CNA #2 returned to the facility to work the 2nd shift, s/he stated her temperature was recorded as normal. The Director of Nursing (DON) was interviewed on 06/27/20 at approximately 6:30 PM and s/he denied that CNA #2 informed him/her of having an elevated temperature during the training. The DON commented that there was no exception for any fever over 100.0 degrees F and the aide should not have stayed in the facility. The DON acknowledged s/he had not conducted an audit of the sign in sheet on 06/27/20. A review of the Centers for Disease Control's guidelines in Preparing for COVID-19 in Nursing Homes, last updated on 6/25/20, indicated, Evaluate and Manage Healthcare Personnel, If HCP develop fever (T 100.0F) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace. Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature* and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. *Fever is either measured temperature >100.0o (degrees) F or subjective fever. 3. A review of Resident's #1 record revealed s/he was admitted on [DATE] and had cumulative [DIAGNOSES REDACTED]. Upon admission to the facility, a laboratory order was added to the chart to collect 1 stool specimen to rule out [MEDICAL CONDITION]. There was no documentation in the chart if the specimen had already been collected. During an observation on the 300 hall on 06/27/20 at 3:00 PM, CNA #1 was observed leaving the room of Resident #1, only wearing a surgical mask. On the door of Resident #1's room, hung a sign that read, New Resident Under Signs and Symptoms Watch for Safety Protocol. Enter with PPE equipment only. There was no PPE equipment hung on the door, outside of the room or inside the room. During an interview with CNA #1 on 06/27/20 at 3:15 PM, s/he acknowledged s/he was unaware that s/he needed to wear full PPE when in the room with Resident #1. CNA #1 mentioned s/he did not know where to find the additional PPE equipment and that there was not any inside of the room. During an interview with RN #1 on 06/27/20 at 3:25 PM, s/he mentioned that Resident #1 was a new admission and that staff only needed to wear a mask when entering the room. During an interview with RN #2 on 06/27/20 at approximately 6:45 PM, s/he was unaware that Resident #1's medical record indicated that Resident #1 was suspected of having [MEDICAL CONDITIONS] ([MEDICAL CONDITION]) and that a stool specimen had been ordered today. Nurse #2 commented that once [MEDICAL CONDITION] was suspected, the resident should be placed on contact precautions and a sign should be hung on her door, and anyone entering the room would need to wear a gown, gloves and a mask. An interview with the DON on 06/27/20 at approximately 6:45 PM revealed that when the lab order to collect stool specimen to rule out [MEDICAL CONDITION] was taken, a sign should have been placed on Resident #1's door to warn of contact precautions and full PPE worn by staff. 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>DON produced a new sign that indicated that Contact Precautions were started after 7:00 pm and that a gown, gloves and mask were required to enter the room of Resident #1. An interview with the Administrator on 06/27/20 at approximately 5:30 PM revealed that new admissions are not in isolation rooms, they were being observed, since the facility had already received their negative COVID-19 test results. S/he had isolation gowns at the nurse's station but did not make them readily available because s/he had a low amount and wanted to preserve them, in the event of an outbreak. A review of the facility's 06/27/20 Infection Control Training In-Service attendance sheet, documented that 21 staff attended the training, along with CNA #2. Review on 06/27/20 of the facility's undated policy on Infection Prevention and Control Program revealed, A system of surveillance is utilized for prevention, identifying, reporting, investigation, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards .A resident with an infection or communicable disease shall be placed on isolation precautions as recommended by current CDC Guidelines for Isolation Precautions. A copy of these guidelines are available at each nurse's station. |