STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425302	A. BUILDING _____ B. WING _____	06/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHESTERFIELD CONVALESCENT CENTER	1150 STATE ROAD CHERAW, SC 29520

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 **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 interview, record review, and facility policy review, the facility failed to properly prevent and contain Coronavirus (COVID)-19 for three (3) of eight (8) sampled residents (Resident #6, #7, and #8). The facility failed to implement quarantine measures for 14 days for Resident #6 and Resident #7 who were admitted from the hospital which created an immediate jeopardy situation starting on [DATE]. Residents #6 and #7 did not remain in their rooms and socialized with resident #8 from another unit, which was around the corner. All three residents were diagnosed with [REDACTED]. The facility implemented corrective actions and removed the immediacy of non-compliance by [DATE]. Findings included: 1. Review of the facility's policy titled, Accepting and Transferring Patients/Residents, ([DATE]) was conducted. The policy noted: Patients/Residents with No Clinical Concerns for COVID-19 -All hospitalized patients/residents should be assessed for COVID-19 prior to transfer to a long-term care facility. If a test is not indicated per Centers for Disease Control and Prevention (CDC) testing criteria, and the patient/resident has no clinical concerns for COVID-19. The following must be implemented: 1. The patient/resident should be placed on a 14-day quarantine on admission from the hospital 2. Based on the facilities (sic) status (respiratory illness present) The resident screening tool should be completed daily for non-respiratory illness facilities, and twice a day for facilities with respiratory illness-on all patients/residents Things to Remember: 1. Patients/Residents on therapy must have therapy completed in their room if they are on isolation and/or quarantine. 2. All Patients/Residents must cover their nose and mouth with tissue, cloth, or mask when care is being provided in their rooms. All Patients/Residents must wear a mask when outside of their room. 3. Patients/Residents should not be in hallways, dining rooms, activity rooms etc. 4. ADL (Activities of Daily Living) care should be completed by as few staff members as possible. Coordinate care to provide multiple jobs during one room entry. The least number of interactions prevents spread of the disease. 2. Per the facility Infection Control Line Listing starting on [DATE] to present, the facility had no residents with COVID-19 on [DATE]. Then on [DATE] the facility had two (2) residents positive for COVID-19. On [DATE] the facility had four (4) residents positive with COVID-19. Upon entry into the facility on [DATE] for the COVID-19 Focused Survey, the facility had 26 residents positive for COVID-19 and seven (7) residents who had expired from COVID-19. 3. During the entrance conference on [DATE] starting around 10:45 AM with the Administrator and Director of Nurses (DON), the Administrator stated the facility's first diagnosed case of COVID-19 was on [DATE]. The Administrator and DON stated at the beginning of [DATE] the facility had three (3) residents (Residents #6, #7, and #8) that liked to socialize together, and staff had to redirect them to social isolate. Per the DON during the entrance conference, residents coming back from the hospital were put on the Observation Unit for 14 days of monitoring. The facility also moved recovered COVID-19 residents to the Observation Unit for 14 days of monitoring before going back to a long-term care room. During an interview on [DATE] at 9:15 AM, the Administrator stated the facility had investigated how the outbreak of COVID-19 began in the building and believed that Resident #6 was the resident who started the outbreak. The Administrator stated she/he and her/his staff found Resident #6, #7, and #8 talking together and they had to redirect them and remind the residents to social distance. During an interview with the Administrator and DON on [DATE] at 12:06 PM, when a resident was admitted from the hospital, they were put on the Observation Unit. The Observation Unit had private rooms so the residents could be separated. The residents received increased monitoring and assessment screening for 14 days following admission. During the timeframe from [DATE] through [DATE], a nurse covered the Observation Unit and part of the North long hall. That practice changed after [DATE]; the nurse and aides only worked on the Observation Unit. The Administrator stated that staff working with Resident #6 had come to her/his concerned about the resident not following the social distancing rules. The Administrator told the staff to redirect the resident and chart about the behavior. During an interview on [DATE] at 2:52 PM, the Administrator stated the facility had no policy defining quarantine. The Administrator stated quarantine meant no visitation from anyone including family or other residents. A resident on the observation unit would be on quarantine and should be in isolation from other residents. 4. Resident #6 was admitted to the facility on [DATE], then transferred back to the hospital on [DATE]. The resident was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the resident's Admission Minimum Data Set (MDS) assessment dated [DATE], Resident #6 was cognitively intact, having scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. The resident had no [MEDICAL CONDITION] or acute onset of mental changes noted. Resident #6 had verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward other one (1) to three (3) days during the assessment period. The resident rejected care and was noted to wander one (1) to three (3) days during the assessment period. The resident required extensive assistance from one (1) person with bed mobility, transferring, locomotion on and off the unit, dressing, toileting, and personal hygiene. According to Resident #6's Discharge Assessment-Return Anticipated MDS dated [DATE], Resident #6 was cognitively intact, having scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #6 rejected care and was noted to wander one (1) to three (3) days during the assessment period. The resident required extensive assistance with one (1) person assistance for bed mobility, transferring, locomotion on the unit, and personal hygiene. The resident required limited assistance with one (1) person for dressing. The resident was totally dependent on one (1) person for locomotion off the unit and toileting. The resident used a wheelchair for locomotion. Review of Resident #6's care plan contained the following problem, dated [DATE]: Resident #6 is a new admission to the facility following a hospital stay for [MEDICATION NAME] (type of bacteria). She/He was alert and oriented but had confusion and disorganized thinking. She/He understood/understands. She/He is having no moods at this time. She/He has hallucinations, delusions, wanders, rejects care, and has verbal behaviors. She/He is receiving skilled therapy services at this time and plans to return home. Family is supportive. Resident #6 likes to socialize with other residents. The facility documented the following approach on [DATE]: Encourage compliance with social distancing and use of mask as resident will allow. Per Psychoactive Medication Monthly Flow Record for [DATE], the staff was monitoring Resident #6 for paranoia behaviors from [DATE] through [DATE]. The resident had no paranoia behaviors noted during this time. On [DATE], the day shift Nurse's Note contained: Resident up in wheelchair at the desk. No respiratory distress oxygen at three (3) liters per minute via nasal canula. Oxygen saturation was 98%. Alert and oriented times one (1), verbally responsive. On [DATE] at 2:55 PM, the Unit Manager's Note contained: Resident noncompliant with staying in her room and wearing mask. Resident redirected several times to wear mask and stay in her room. On [DATE] at 9:00 PM, the Nurse's Note contained: At Nurses' Station in wheelchair. Alert and verbally responsive, refused all 9:00 PM medications. Keeps attempting to get out of wheelchair. No sign/symptoms of acute distress. On [DATE] at 6:00 AM, the Nurse's Note contained: Resident attempting to climb out of bed, alert, refused finger stick blood sugar check. The resident was combative. On [DATE] the day shift Nurse's Note contained: Resident up in wheelchair at desk. Alert and oriented times one (1), verbally responsive to staff. No respiratory distress. Oxygen as ordered via nasal cannula. Incontinent of bowel and bladder, bowel sounds times four (4) quadrants, abdomen soft and nondistended. Therapy as ordered. On [DATE] at 3:00 PM the Unit Manager's Note contained: Resident noncompliant with wearing mask and staying in her room. On [DATE] at 10:00 PM the Nurse's Note contained: Resident

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) in bed, alert, skin warm/dry. No signs/symptoms of diabetic distress. Resident refuses finger stick blood sugar or 9:00 PM medications. On [DATE] at 9:00 PM the Nurse's Note contained: Refused evening medications and finger stick blood sugar checks. Combative when approached. Alert and verbally responsive. Skin warm/dry. No signs/symptoms of acute distress. Review of the SBAR (Situation-Background-Assessment-Recommendation) Communication Form dated [DATE] at 3:29 PM revealed the resident had an increased heart rate of 144 beats per minute and shortness of breath with respirations at 26 breaths per minute. The resident's temperature was 98.9 degrees Fahrenheit. The Physician ordered the resident to be sent to the emergency room to be evaluated. At this time, the nursing staff also filled out Suspected COVID-19 Infection SBAR form due to the resident having a change of condition, a respiratory rate greater than 25 breaths/minute, and an age of 65 or older. The resident was discharged to the hospital on [DATE] with increased and irregular heart rate of 144 beats a minute, shortness of breath and increased respirations 26 breaths a minute. The facility was notified on [DATE] of the resident's COVID-19 positive test. At the time of survey, the resident was still at the hospital. In an interview on [DATE] at 3:04 PM the North Unit Manager stated Resident #6 was on the Observation Unit after being admitted back to the facility on [DATE]. The resident was on 14 days of quarantine, meaning the resident was supposed to stay in the room and have no contact with other residents. Resident #6 was combative, refused medications, staying in her/his room, and wearing a mask if out of the room. The Unit Manager and the unit staff redirected Resident #6 back to the resident's room and tried to have the resident apply a mask. The Unit Manager stated she/he brought her/his concerns to her/his supervisor about Resident #6 not following social distancing and quarantine. The double doors to the Observation Unit were not closed when Resident #6 was residing on the unit, which allowed the resident to go to other units and residents from other non-restricted units to come onto the Observation Unit. In an interview on [DATE] at 3:04 PM, CNA #1 stated Resident #6 was very combative, anything he/she tried to do with the resident, the resident refused. CNA #1 stated he/she had to get the nurse to help intervene with the resident; sometimes the nurse could get the resident to do what the CNA needed her/him to do. Anytime the resident was in the wheelchair, she/he rolled out into the hallway or into other residents' rooms on the unit. The resident refused to wear a mask if out of the room. The CNA stated they tried to redirect Resident #6 back to her/his room or to put a mask on him/her while out in hallway or unit. CNA #1 stated she/he notified her/his nurse of her/his concerns. 5. Resident #7 was admitted from the hospital to the facility on [DATE]. The resident was quarantined on the Observation Unit for 14 days. The resident had [DIAGNOSES REDACTED]. According to the Resident's Admission MDS assessment dated [DATE], Resident #7 was severely cognitively impaired, having scored three (3) out of 15 on the BIMS assessment. The resident had no wandering noted during the assessment period. The resident required limited assistance with one (1) person assistance with bed mobility, transfers, locomotion on and off of the unit, dressing, toileting, personal hygiene and bathing. The resident used a wheelchair for locomotion. The Resident's care plan was reviewed; nothing was documented about the resident wandering out of the room or on to the unit. Review of the SBAR Communication Form dated [DATE] at 11:45 PM revealed, the resident had an increased heart rate of 126 beats per minute and a temperature of 100.4 degrees Fahrenheit. The Physician ordered the resident to be sent to the emergency room to be evaluated. At this time the nursing staff also filled out Suspected COVID-19 Infection SBAR form due to the resident having fever higher that 99.6 degrees Fahrenheit and pulse greater than 100 beats a minute. During an interview on [DATE] at 3:04 PM, CNA #1 stated Resident #7 was confused and wandered out of her/his room. The CNA stated the resident wandered the hallway looking for her/his room. The staff redirected the resident back to her/his room, but the resident said that wasn't her/his room. The resident went to other residents' rooms to look for her/his room. The resident opened the door if someone was in the room the resident would go in to ask where her/his room was located. The resident was confused so the staff had problems with her/him keeping a mask on him/her or even putting a mask on when he/she was out of the room. In an interview on [DATE] at 3:04 PM, the North Unit Manager stated Resident #7 was on the Observation Unit after being admitted to the facility on [DATE] from the hospital. The resident was on 14 days of quarantine, meaning the resident was supposed to stay in the room with no contact with other residents. The resident came out of her/his room at times. The staff redirected the resident back to her/his room and tried to get the resident to wear a mask when out of the room. 6. Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the resident's Admission MDS assessment dated [DATE], Resident #8 was severely cognitively impaired, having scored five (5) out of 15 on the BIMS assessment. The resident was coded as having inattention behavior and disorganized thinking that was present but fluctuated throughout the day. The resident required extensive assistance with one (1) person for bed mobility and transfers. The resident was dependent with one (1) person assistance for locomotion on and off the unit, dressing, toileting, personal hygiene, and bathing. The resident used a wheelchair for locomotion. The resident was discharged to the hospital on [DATE] with yellow drainage at nephrostomy site, bilateral lower extremity discoloration with coldness to touch, heart rate 114 beats a minute, and labored breathing. The facility was notified the resident tested positive for COVID-19. Resident #8 was readmitted to the facility on [DATE], onto the COVID-19 positive unit. In an interview on [DATE] at 3:04 PM the North Unit Manager stated Resident #8 was off of the Observation Unit and currently resided on the North Long Hall Unit. The resident had completed 14 days of quarantine before [DATE] and was allowed to be out of his/her room. The resident sat in the wheelchair near the nurses' station during the day separated from other residents. The resident wheeled her/himself in the wheelchair short distances. 7. Per review of the facility's resident Infection Control Line Listing starting on [DATE] to present and record review, Residents #6 and #7 resided on the Observation unit on the North hall and Resident #8 resided on the North long hall, which was not part of the Observation Unit. Per the Infection Control Line Listing, Resident #6 was sent to the hospital on [DATE] with an increased heart rate of 144 beats per minute and shortness of breath with respirations at 26 breaths per minute. The resident's temperature was 98.9 degrees Fahrenheit. The facility was notified of the positive COVID-19 test on [DATE]. Per the information from the Infection Control Line Listing, Resident #8 was sent to the hospital on [DATE] with a temperature of 100.3 degrees Fahrenheit and heart rate of 124 beats a minute. The facility was notified of the positive COVID-19 test on this date. Per the information from the Infection Control Line Listing, Resident #7 was sent to the hospital on [DATE] with yellow drainage at nephrostomy site, bilateral lower extremity discoloration with coldness to touch, heart rate 114 beats a minute, and labored breathing. The facility was notified of the positive COVID-19 test. 8. On [DATE] at 4:45 PM the Administrator stated Resident #6 had the right to move about. The Administrator stated the facility, cannot keep her/him locked up. The Administrator stated Residents #6, #7 and #8 were observed talking at the double doors on the Observation Unit. During that time the double doors to the Observation Unit were not closed. The Administrator stated these were three (3) alert and oriented residents and stated she/he could not tell then what to do. The Administrator stated they had the right to go about the building. 9. Per record review noted above, Resident #7 had a BIMS score of three (3) and Resident #8 had a BIMS score of five (5). Both residents had severely impaired cognition.