| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **425096** | A. BUILDING _____ B. WING _____ | **08/06/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **VALLEY FALLS TERRACE** | **400 LOCUST GROVE ROAD SPARTANBURG, SC 29303** |

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<br><br>**Level of harm -** Immediate jeopardy<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, interviews, record reviews, and review of the facility's Accepting and Transferring Patients/Residents policy, the facility failed to prevent the potential transmission of COVID-19 between facility residents for eight of 12 sampled residents (Resident #1, Resident #8, Resident #9, Resident #10, Resident #6, Resident #12, Resident #7,and Resident #11). The facility admitted the residents from the hospital to the general population in rooms with other residents and did not cohort or quarantine the newly admitted residents to prevent the potential spread of COVID-19. The facility's failure had the potential to affect all 79 residents that resided at the facility. The facility Administrator was informed on 08/05/20 at approximately 8:55 PM that Immediate Jeopardy existed on 07/28/20. The facility provided an Immediate Jeopardy Removal Plan that was accepted on 08/06/20 at approximately 3:19 PM and the Immediate Jeopardy at F880 was removed with an effective completion date of 08/06/20 and lowered to the scope and severity of E. The findings include: 1. Review of Resident #1's undated, Face Sheet, located in the resident's hard copy medical record, revealed the resident was readmitted to the facility on [DATE] from the local hospital. Review of Resident #1's COVID-19 test results provided by the facility, dated 07/20/20 revealed the resident's test results were positive for COVID-19. Review of Resident #1's Discharge Note, dated 07/20/20, found in the resident's hard copy medical record, revealed the resident was discharged to a sister facility. Continued review of the discharge note revealed Patient is a 94yo (year old) with multiple comorbidities who was residing at Valley Falls for long term care. He/she received a COVID test due to staff members testing positive at the facility. His/her covid (sic) test was positive. He/she has no symptoms that were reported and stable at the time of transfer . Observation on 08/05/20 at 2:12 PM of Resident #1's room revealed the resident's curtain was pulled around the resident. The resident shared the room with three other residents (Resident #8, Resident #9, and Resident #10). Review of Resident #8's undated Face Sheet, provided by the facility, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Continued review of the resident's face sheet revealed the resident currently resided in the room with Resident #1. Review of Resident #9's undated Face Sheet, provided by the facility, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Continued review of the resident's face sheet revealed the resident currently resided in the room with Resident #1. Review of Resident #10's undated Face Sheet, provided by the facility, revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Continued review of the resident's face sheet revealed the resident currently resided in the room with Resident #1. Interview on 08/05/20 at 2:14 PM, with the Infection Preventionist (IP), revealed Resident #1 initially tested positive for COVID-19 on July 20th. Continued interview revealed the resident was sent to the facility's sister facility to be on a COVID unit. The IP stated during the resident's stay at the sister facility, the resident had a fall and had to be sent out to the hospital. The IP also stated while at the hospital, Resident #1 was tested for COVID and the test result was negative; and then the resident was readmitted back to the current facility on 07/31/20. Further interview with the IP revealed Resident #1 was placed on observation in a ward with three other residents (Resident #8, Resident #9, and Resident #10) and was not on any precautions (transmission based precautions). The IP stated staff only had to wear a mask when going into the resident's room and wore gloves when providing care. When asked where this guidance came from, the IP stated, it came from corporate. Review of an email dated 04/06/20, provided by the IP, revealed the email originated from the Clinical Services Director (CSD). Continued review of the email revealed New Guidance is as follows: New patients/residents who enter the facility should be screened for COVID-19 through testing, if available. We recommend quarantining all new admissions for 14 days. That does not mean you use PPE but that the resident remains in their room .Full PPE should be worn for any residents with known or suspected COVID-19. If transmission has occurred in the facility-all staff should wear full PPE for all residents regardless of COVID-19 [DIAGNOSES REDACTED]. The IP stated the resident was considered quarantined because he/she had his/her curtain pulled completely around him/her and the resident would not be coming out of his/her room. Interview on 08/05/20 at 3:00 PM with the Administrator revealed quarantine was keeping the resident isolated in their room for 14-days. The Administrator stated they only use PPE for isolation precautions. The Administrator gave the following example: A resident who tested positive for COVID-19 would be moved out of their room and then their roommate would be placed on droplet isolation precautions and then staff would be required to wear full PPE when entering the room for 14-days. The Administrator stated for admissions and readmissions, only quarantine is done. Interview on 08/05/20 at 4:20 PM with the IP revealed the three other residents in room the room with Resident #1 (Resident #8, Resident #9, and Resident #10) were long term residents and were not newly admitted residents. According to the IP, since this was Resident #1's room for a long time, the IP put the resident back in the same room when he/she returned from the other facility. The IP also stated the resident's roommates were placed on isolation droplet precautions for 14 days after his/her positive COVID test results on 07/20/20. He/she further revealed the resident's roommates had finished isolation droplet precautions before Resident #1 returned to the facility. Interview, on 08/05/20 at 4:27 PM, with Certified Nursing Assistant (CNA) #6 revealed he/she was responsible for Responsible for a group of rooms, which included Resident #1's room. When asked if any residents he/she was responsible for were on quarantine, CNA#6 stated no. When asked what quarantine meant, the CNA stated it meant she would gown up with PPE. When asked if there was anything different about anyone in room [ROOM NUMBER], the CNA stated Resident #1 was on isolation, he/she was to keep his/her curtain pulled, and he/she was to use universal precautions with the resident. Interview on 08/05/20 at 4:30 PM with Licensed Practical Nurse (LPN) #7 revealed he/she was Resident #1's nurse that day. Continued interview revealed when asked if Resident #1 was quarantined, the LPN stated, no sir, but the resident's temperature was to be monitored twice a day. 2. Review of Resident #6's undated Face Sheet, located in the resident's hard copy medical record, revealed the resident was admitted to the facility on [DATE]. Review of Resident #6's COVID-19 Test Result, dated 07/29/20 revealed a negative test result. Continued review of the test result revealed the resident was tested for COVID-19 on 07/28/20 and the result was dated 07/29/20, which indicated the resident was admitted to the facility before his/her results and placed in a general population room with another resident (Resident #12). Review of Resident #12's undated Face Sheet, revealed the resident was admitted to the facility on [DATE]diabetes mellitus type 2, [MEDICAL CONDITION], and [MEDICAL CONDITION]. Continued review of the resident's face sheet revealed the resident currently resided in the room with Resident #6. Interview on 08/05/20 at 4:00 PM, with LPN#2, revealed he/she was Resident #6's nurse. Continued interview revealed Resident #6 was still quarantined, which included getting his vitals taken. The LPN stated Resident #6's roommate was not a new admission and was not on quarantine. LPN#2 further stated he/she did not have to wear any PPE other than mask when going into the resident's room and the resident's curtain was supposed to remain closed. Observation on 08/05/20 at 4:05 PM, of Resident #6's room, revealed Resident #6's privacy curtain was not pulled, and the resident could be seen from the hall. Continued observation revealed LPN#2 entered the resident's room and pulled his/her privacy curtain, but not completely. 3. Review of Resident #7's undated Face Sheet, located in the resident's hard copy medical record, revealed the resident was admitted to the facility on [DATE]. Review of Resident #7's COVID-19 Test Result, dated 08/04/20, revealed a negative test result. |

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

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| F 0880<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 1)<br>Continued review of the test result revealed the resident was tested for COVID-19 on 08/03/20 and the results was dated 08/04/20, which indicated the resident was admitted to the facility before his/her results and placed in a general population room with another resident (Resident #11). Review of Resident #11's undated, Face Sheet, provided by the facility, revealed the resident was admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Continued review of the resident's face sheet revealed the resident currently resided in the room with Resident #7. Interview on 08/06/20 at 3:38 PM, with the Administrator, revealed he/she felt like the facility was following the instructions that were given to them from their consultants. The Administrator stated he/she thought they were doing admitting and quarantining correctly, due to the minimum number of COVID positive cases the facility has had. Review of the facility's undated policy titled, Accepting and Transferring Patients/Residents, revealed Patients/Residents with No Clinical Concerns for COVID-19. All hospitalized patients/resident 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. Based on the facilities 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. The Immediate Jeopardy Removal Plan included the following: Summary of Incident: Resident #1, Resident #6, and Resident #7 were all admitted to the facility and placed in the general population rooms with other residents who were not newly admitted residents and were not on any type of quarantine. The facility's lack of cohorting placed not only the five residents that Resident #1, Resident #6, and Resident #7 shared a room with, but also placed the whole facility at risk for possible spread of COVID-19. The facility removed the immediacy by creating a quarantine unit within the facility. The facility then assessed the newly admitted residents and their roommates, who had been potentially exposed, and placed the residents on the quarantine unit with transmission-based precautions (TBP). The facility has initiated the below education plan for all nursing, social services, admission, and contracted staff including housekeeping staff. Immediate Changes to Facility Systems: The facility revised the following policy: Coronavirus Disease 2019 (COVID-19) Pandemic Prevention and Response Plan, to include the subject of Quarantine Units. The facility will establish designated units/halls/ or sections of the facility for a quarantine unit to safeguard those residents who are new admissions, left the facility for appointments and/or have a unknown status of COVID-19. The facility will provide full PPE to include gown, gloves, facemask, goggles, or face shields to the staff who is assigned to the quarantine unit to ensure safe interactions with residents of unknown status. The facility leadership will identify an area of the facility to house residents for a period of 14-days to better control the threat of COVID-19. The facility will house all new admissions on the designated quarantine unit for a minimum of 14 days. The facility will house all residents who leave the facility for physician, ER visits, [MEDICAL TREATMENT] appointments, LOAs (leave of absences), or any other reason on the quarantine unit for a minimum of 14-days. The facility will test resident that reside on the quarantine unit as necessary and then transfer to appropriate unit if necessary, e.g., resident test positive for COVID-19 then transferred to COVID-19 unit for 14 days. The facility will complete resident screenings at least three time per day, and at least once per shift for early identification of signs or symptoms of illness and prompt placement in the appropriate unit. This will be completed on 08/06/20. The facility will include in its daily stand-up meeting Monday through Friday of the admissions and readmissions being reviewed by the administrator and members of nursing management to validate location on the designated quarantined hall. Shift to shift reports between all nursing staff and signage on the resident's doors will be the method of communication for the staff to know assignments for their shift, and designated areas for donning and doffing of full PPE for TBP. Education Plan: Upon notification of the immediate jeopardy, education was initiated for all staff in the building at the time of the notification to ensure all staff were aware of the newly developed quarantine unit and the proper quarantine procedures now in place. The education continued at the beginning of each shift of all staff coming on duty through out the next day following the notification of the Immediate Jeopardy. All other facility staff including staff on all types of leave will be required to complete the education outlined prior to beginning their next shift. Monitor removal plan outcomes: The Administrator will report to Quality Assurance (QA) all contents of the removal plan (as outlined in this summary of incident) monthly for review and recommendation until the pandemic plan is no longer necessary. Completion Date: 08/06/20 |
| F 0885<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review, and review of the facility's website for COVID-19 communication, it was determined the facility failed to ensure residents, residents' representatives, and residents' families of the facility were notified by 5:00 PM the following day after a resident of the facility tested positive for COVID-19. On 07/20/20 the facility was notified Resident #1 tested positive for COVID-19; however, the facility did not update their COVID-19 communication web page to reflect the positive case until 07/24/20, four days after the facility received the positive results. The facility's failure had the potential to affect all residents, residents' representatives, and residents' families of the facility. The facility census was 79. Findings include: Interview on 08/06/20 at 3:38 PM, with the Administrator, revealed the facility did not have a policy related to notifying residents and families after a COVID-19 positive case. Review of Resident #1's undated, Face Sheet, located in the resident's hard copy medical record, revealed the resident was admitted to the facility on [DATE]. Review of Resident #1's COVID-19 test results provided by the facility, dated 07/20/20, revealed the resident's test results were positive for COVID-19. Review of the facility's website http://www.valleyfallsterrace.com/covid19.html, revealed the facility's COVID-19 updates were completed on 07/24/20; however, there were no updates between 07/20/20 and 07/24/20, which indicated the facility did not communicate the positive COVID-19 test results of a resident by 5:00 PM the following day after the resident's positive result. Interview on 08/06/20 at 3:38 PM, with the Administrator, revealed it was his/her understanding that once he/she put the information, after a COVID positive case, into the facility's web system, a notification letter would have been generated and be on the facility's website to meet the required time frame. Continued interview revealed that to his/her knowledge, the required timeframe was not met and had not realized the issue until a couple of weeks ago. |