STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425048	A. BUILDING _____ B. WING _____	08/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUE RIDGE IN GEORGETOWN	2715 SOUTH ISLAND ROAD GEORGETOWN, SC 29440

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** - 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 reviews, facility policy review and review of the Centers for Disease Control guidelines for COVID-19, it was determined: 1. The facility failed to establish a dedicated COVID-19 unit to isolate and/or cohort COVID-19 positive residents. Four rooms in the facility (Rooms 11, 30, 39 and 42) previously cohorted positive COVID-19 residents (Residents #4, #6, #8 and #19), as well as negative COVID-19 residents (Residents #2, #5, #12 and #17) in the same rooms; 2. The facility failed to use dedicated staff to care for the COVID-19 positive residents; 3. The facility failed to utilize full PPE (personal protective equipment - gown, N95 masks, face shield and gloves) when caring for one of one newly admitted resident (Resident #1); 4. The facility failed to utilize an effective surveillance screening tool to monitor COVID-19 outbreaks for the residents and staff; 5. The facility did not ensure that two of 13 staff (Social Worker and Licensed Practical Nurse #1) wore face masks without exposing their nostrils, to prevent the transmission of COVID-19; 6. The facility failed to screen one of two visitors (surveyor) for symptoms of COVID-19 upon entering the facility. The findings included: 1. On [DATE] at 12:15 PM, the Administrator escorted the surveyor to the Jones Hall Solarium, which was at the end of the hall. Outside of the nurse's station on the Jones hall, was a plastic zip wall that hung from the ceiling, with the flaps of the wall, opened and pinned back. The Administrator was asked if we were entering a COVID-19 positive unit and he stated no, the plastic zip wall was still hung on the hall from another time when the facility had isolated their residents. As of yesterday, the Administrator commented, the facility no longer had any positive COVID-19 cases. On [DATE], the plastic zip wall was removed from the Jones hall. Four rooms in the facility (Rooms 11, 30, 39 and 42) previously cohorted positive COVID-19 residents (Residents #4, #6, #8 and #19), as well as negative COVID-19 residents (Residents #2, #5, #12 and #17) in the same rooms. On [DATE] at 12:20 PM, the Director of Nursing (DON) stated s/he had been the Infection Control Nurse since [DATE] but had only been the DON for two weeks. Their census was 52 and s/he believed that the facility overall had 28 residents who had been COVID-19 positive. Eight staff had tested positive, too. Three of their residents (Residents #3, #7 and #18) died from COVID-19 and two residents (Residents #10 and #11) were sent to the hospital on [DATE]. Both Residents #10 and #11 had already tested positive for COVID-19 on [DATE] and [DATE] respectively; however, their symptoms worsened. The Administrator explained that the facility started to conduct rapid testing on residents at the end of July and discovered that some of the residents were positive. S/he further explained that due to the size of their building, they were unable to isolate the residents who tested positive to a separate unit, but they still accepted new admissions. A decision was made by their Medical Director, that if there were two residents in a room, the resident who tested negative to COVID-19 would move out of the room, be placed in a private room, and would be monitored for COVID-19 symptoms for 14 days, but they normally extended it to 20 days. The roommate who was positive for COVID-19 and who was asymptomatic, would be paired with another COVID-19 positive resident of the same gender. The Administrator stated, We don't like to move symptomatic residents out of their rooms. If the residents were coughing, we did not want them in the hallway, even if the resident wore a mask. The zip wall on the Jones hall, was never intended for the dedicated COVID-19 unit. It was the location, where they intended to place all their new admissions and a resident who received [MEDICAL TREATMENT] care. An interview was conducted on [DATE] at 3:15 PM with Registered Nurse (RN) #1, who indicated that if a resident tested positive for COVID-19, the resident would remain in the room. The roommate would be tested to determine if also positive for COVID-19. If the roommate was negative and did not want to leave the room, they would counsel the roommate on the risks and benefits of leaving the room. RN #1 stated it was the roommate's right to remain in the room with a resident who was positive for COVID-19. The nurse would speak with the family once the [DIAGNOSES REDACTED].#2 who stated that it was also the resident's right to stay in the room with a resident who tested positive, even though the resident was negative. RN #2 indicated that COVID-19 could be spread by moving positive COVID-19 residents from their rooms. Residents sometimes received false negative COVID-19 results, so they presumed that they (both roommates) were positive to COVID-19 and should be left in the room. During an interview with the Environmental Services Manager on [DATE] at 11:47 AM, s/he revealed that the original design was to use rooms ,[DATE] on the Mitchell hall for COVID-19 positive residents. An interview was conducted with the Administrator on [DATE] at 5:45 PM. S/he acknowledged that the facility originally installed the plastic zip lock wall on the Jones unit for the COVID-19 positive residents during [DATE]. However, their Medical Director didn't feel it was necessary due to the number of outbreaks that they had in July. Residents were kept in their rooms and the roommate was presumed to be already exposed. Review of a memo from the Center for Disease Control (CDC) website, dated [DATE], titled, Responding to Coronavirus (COVID-19) in nursing homes, regarding establishing a COVID-19 unit, stated: Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19. Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms. If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 (COVID-19) 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. On [DATE] at 5:45 PM, an interview was conducted with the Administrator and DON. They acknowledged that they did not establish a dedicated COVID-19 unit. 2. An interview was conducted on [DATE] at 3:50 PM with the Rehabilitation Director. S/he stated that therapy was briefly shut down when the facility had an outbreak of COVID-19. The therapy department only had one Speech Language Pathologist and Physical Therapist, so they were not able to use them as dedicated staff to residents who tested positive to COVID-19. The rehab staff were instructed to work clean to dirty and save the residents who tested positive for COVID-19 last. Staff would disinfect equipment with wipes and pull the privacy curtain between the roommates. On [DATE] at 5:45 PM, an interview was conducted with the Administrator and DON. They acknowledged that they did not establish a dedicated COVID-19 unit or have dedicated staff for COVID-19 positive residents. Review of a memo from the CDC website, dated [DATE], titled, Responding to Coronavirus (COVID-19) in nursing homes stated: Assign dedicated Healthcare Personnel (HCP) to work only on the COVID-19 care unit. At a minimum this should include the primary Certified Nursing Assistants (CNAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility. To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit. Assign environmental services (EVS) staff to work only on the unit. If there are not an enough environment service staff to dedicate to this unit despite efforts to mitigate staffing, restrict their access to the unit. Also, assign HCP dedicated to the COVID-19 care unit (e.g., CNAs) to perform cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. 3. Resident #1 was admitted to the facility on [DATE], the Minimum Data Set (MDS) assessment had not been completed. During tours on [DATE] and [DATE], Resident #1 was observed in bed, wearing a face

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) mask, around his/her chin. S/He was not observed to leave his/her room and the door to his/her room remained open, with no isolation precaution signs present. There was no station outside of his/her door for staff to put on PPE before entering his/her room. There were no bio-hazard barrels, to store soiled PPE equipment in his/her room. On [DATE] at 2:00 PM, Housekeeper #2 was observed cleaning some of the rooms on the Jones Hall. Only one room on the hall had a sign warning of droplet precautions. The housekeeper had just exited the room with the sign and was seen wearing a gown, mask, face shield and gloves. The housekeeper was interviewed, and s/he indicated s/he did not have Resident #1's room on his/her assignment but s/he had never put on full PPE to clean the room. S/he commented, I gown up based on the sign on the door. On [DATE] at 2:05 PM, an interview was conducted with the DON regarding their new admission policy during COVID-19. S/he commented that the facility was told by DHEC (South Carolina Department of Health and Environment Control) that new admissions only needed to be watched for 14 days. They were never required to isolate a new admission. The DON further commented that s/he had no expectations for his/her staff to wear full PPE when entering the room of Resident #1. The DON stated that when Resident #1 was admitted on [DATE], s/he was positive and when s/he used the rapid test on [DATE], Resident #1 was negative. On [DATE], review of the facility's Admission of Residents with Communicable Disease Policy, dated [DATE], indicated that, Admissions requiring infection control restrictions will be placed on appropriate isolation precautions based on this facility's policies governing isolation precautions. Further, a copy of the facility's Droplet Precautions sign was reviewed and read to, perform hand hygiene; mask is indicated upon entry and within 6 feet of a contagious individual; before leaving room, remove and discard personal protective equipment and perform hand hygiene. Review of a memo from the CDC website, dated [DATE], titled, Responding to Coronavirus (COVID-19) in nursing homes stated: Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (healthcare personnel) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. 4. The DON was interviewed on [DATE] at 12:30 PM. S/he indicated the facility had experienced 28 residents who tested positive to COVID-19, three residents had died , and eight staff had been infected. The DON was asked how many residents currently were in isolation and s/he reported one resident, who was on [MEDICAL TREATMENT]. The residents' medical appointments had been canceled by their health providers. Therefore, s/he never had a need to isolate and s/he did not think that s/he had any resident who had gone to the emergency room and later returned to the facility. The facility had new admissions since COVID-19, but s/he did not have anyone on isolation now that was a new admission. The DON indicated that s/he had not maintained a list of residents who needed to be put on isolation. Later in the day, the DON produced a Midnight Census Report from [DATE] that had inserted dates [DATE], [DATE], [DATE], [DATE] when s/he conducted rapid testing for COVID-19. Beneath each date, it stated if the resident had tested positive for COVID-19. A resident who was admitted on [DATE] was handwritten on the form, however the resident had discharged to the hospital on [DATE]. Resident #1 was missing from the form, and there was no recorded information regarding Resident #1's COVID-19 status. In total, the data indicated that 33 residents had been infected with COVID-19 and four residents had died . On [DATE] at 5:30 PM, the DON produced a handwritten list of staff who tested positive for COVID-19. The number of staff had grown from eight to 14. In addition, on [DATE] at 10:00 AM, the DON provided an updated staff roster of employees who tested positive and the list grew to 16, with dates of testing that ranged [DATE] to [DATE]. The DON indicated that s/he had not been able to determine how COVID-19 started in the facility, but s/he thought it came from staff and suspected from one or two staff, who had bad cases and were out the longest. The DON indicated that s/he completed a web-based nursing home infection preventionist training course on [DATE]. On [DATE], the facility's Long-Term Care (LTC) Respiratory Surveillance Line List, dated [DATE], was reviewed. The instructions stated that it, provided a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak at a nursing home. Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measured by identifying units where cases are occurring. 5. An interview was conducted on [DATE] at 3:45 PM with Licensed Practical Nurse (LPN) #1. S/he was sitting behind the nurse's station and wore a cloth face mask that had a loose fit and exposed her nostrils. LPN #1 acknowledged that his/her nostrils were exposed because if the mask covered his/her nose, it became aggravating when his/her eyeglasses steamed up. An interview was conducted on [DATE] at 4:20 PM with the Social Worker who wore a cloth mask that exposed his/her nostrils. The face mask was too large, and the Social Worker kept trying to readjust it, but the mask would not stay in place. The Social Worker was asked if the mask had a wire across the nose, to adjust the fit and s/he commented no. On [DATE] at 5:40 PM, the Administrator was made aware that not all staff wore their face mask properly. S/He commented that s/he had noticed that the Social Worker's face mask did not have a good fit. The facility did not provide surgical masks; most employees wore cloth masks. Review on [DATE] of CDC guidelines How To Wear A Mask dated [DATE] stated, Put if over your nose and mouth and secure it under your chin. 6. On [DATE] at 12:10 PM, the surveyor entered the facility and was greeted by the Receptionist and the Administrator. The surveyor was not screened by staff upon entry. On [DATE] at 2:45 PM, the Director of Nursing (DON) was asked about their procedures for screening visitors. S/he commented that once the doorbell rings, the visitor should be brought inside the lobby in the waiting area to have their temperature checked and be given a questionnaire to complete. The receptionist would provide hand sanitizer and a face mask. On [DATE] at 3:00 PM, an interview was conducted with the Receptionist. S/he acknowledged that s/he was supposed to record all visitor's temperature and ask questions regarding COVID-19 signs and symptoms. S/he indicated s/he thought about going to the solarium to record the surveyor's temperature when s/he realized it should have been taken. On [DATE], the facility provided the policy, CMS (Center for Medicaid and Medicare Services) COVID-19 Long-Term Care Facility Guidelines, dated [DATE]. It read, Long-term care facilities should immediately implement symptoms screening for all. In accordance with previous CMS guidance, every individual regardless of reason entering a long-term care facility should be asked about COVID-19 symptoms and they must also have their temperature checked.