| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **425104** | A. BUILDING _____ B. WING _____ | **09/03/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **PRUITTHEALTH- BAMBERG** | **439 NORTH STREET BAMBERG, SC 29003** |

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 -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, observations, staff interviews, and policy review the facility failed to: 1. Ensure that Environmental Services (ES) staff followed proper hand hygiene practices during the resident room cleaning process. The ES staff provided cleaning services for the facility with a census of 54 residents. 2. Provide personal protective equipment (PPE) to family members that were visiting a COVID-19 positive resident (Resident #1) during a [MEDICATION NAME] care visit and to develop and implement a process for how to protect residents' family members during [MEDICATION NAME] care visits. The facility had two residents (Resident #1 and Resident #3) who were visited by five family members during their dying process and none of the family members were screened upon entry to the facility and four family members were not offered PPE to wear during their visit with their family member who was COVID-19 positive. The failed practices had the potential to spread infection throughout the facility. Findings include: 1. During an observation on [DATE] at 9:40 AM, on 100 Hall, Environmental Services (ES) #1 completed cleaning a resident's room, went to his/her housekeeping cart and removed his/her gloves, threw them in the trash, and proceeded to put on another set of gloves. The surveyor stopped ES#1 and asked if there was something, he/she needed to do after removing gloves and applying the clean pair of gloves. ES #1 thought about the question and answered, Sanitize my hands, which he/she proceeded to do. ES #1 said that he/she knew to use the hand sanitizer but forgot. During an observation on [DATE] at 10:20 AM, on 100 Hall, after cleaning a resident's bathroom, ES #2 was moving onto another task and had not changed her gloves. The surveyor intervened and questioned ES #2 about changing gloves. ES #2 remembered and said the gloves needed to be changed and hands sanitized in between. The surveyor asked ES #2 about handwashing/infection control education and ES #2 did respond, yes, without providing more information. During an observation on [DATE] at 10:40 AM, on 200 Hall, ES #3 was preparing to enter a resident's room and started to don gloves when the surveyor intervened and questioned ES #3 about what he/she needed to do prior to putting on gloves. ES#3 said, sanitize my hands and further stated, I was not thinking. ES #3 proceeded to look for hand sanitizer on his/her cart and could not locate any. ES #3 left the area, obtained a bottle of hand sanitizer, came back to cart, used the sanitizer and donned his/her gloves. When questioned about education provided on hand washing, ES #3 stated, Just watched a video. In an interview on [DATE] at 11:10 AM, with the Environmental Services Manager (ESM), he/she stated, he/she did not have documentation of the Environmental Services staffs' education regarding COVID-19, infection control, hand hygiene, or donning/doffing of PPE. ESM stated his/her staff did complete a computer module in(NAME)University titled, COVID Sanitation. ESM was unable to provide additional documentation of infection control/handwashing training. ESM said he/she does observe/monitor his/her staff performing their job duties and corrects them if they are not following appropriate infection control practices. Throughout the two-day survey, the surveyor requested the Administrator provide documentation of staff education provided in relation to COVID-19, specifically on handwashing, donning and doffing of PPE, and infection control. During an interview on [DATE] at 9:20 AM, the Administrator, stated he/she could not locate the education that was completed with the facility's staff regarding COVID-19. The Administrator explained that he/she did contact the former employee that was in charge of staff education, who stated that the information was in his/her office. The Administrator stated he/she searched the employee's office but could not locate the documentation of staff education. 2. A review of Resident #1's Face Sheet found in the electronic medical record (EMR) under the Admissions Tab indicated the facility admitted Resident #1 on [DATE] with the [DIAGNOSES REDACTED]. A review of Resident #1's Progress Notes found in the EMR under the Progress Notes Tab on [DATE] at 3:24 AM, stated, Patient C-19+, precautions continued.; on [DATE] at 2:28 AM stated, Patient C-19+; precautions continued.; on [DATE] at 4:31 AM, abnormal vital signs were noted and contact was made with Resident#1's responsible party who stated they would come in and see Resident#1 at the facility. Resident #1 died at 9:30 AM. A review of Resident #3's Face Sheet found in the EMR under the Admissions Tab indicated the facility admitted Resident #3 on [DATE] with the [DIAGNOSES REDACTED]. and dementia. A review of Resident #3's Lab Test Results found in the EMR under the Resident Documents Tab indicated on [DATE] and [DATE] Resident #3 was positive for COVID-19. A review of Resident #3's Progress Notes found in the EMR under the Progress Notes Tab indicated: dated [DATE] stated, C-19+; precautions continued. A Progress Note dated [DATE] stated, Patient is hospice with COVID. A Progress Note dated [DATE] at 9:29 AM stated, Daughter .at bed side; resident has 0 respirations and pulse. Review of the facility's policy, Coronavirus (COVID-19) Infection Prevention and Control Practices Policy, revised [DATE] stated, Policy Statement: It is the policy of the (name deleted) organization to initiate the appropriate measures to protect our patients/residents, partners and families from risks associated with the Coronavirus (COVID-19) through mitigation and educational tools, utilizing resources as provided by the Department of Public Health and Centers for Disease Control . II. Screening of Partners, Visitors and Vendors 1. All locations are required to setup screening stations at the main entrance to screen . visitors for the following: Travel to area where there are ongoing outbreaks of COVID-19, Contact with someone who has or is suspected to have COVID-19, Fever, Cough, Shortness of Breath, Sore Throat, Fatigue, Chills, Sweats. 2. The screening station should include the following supplies: Alcohol Dispenser (at least 60%), Gloves, Germicidal Wipes, Procedure Masks . VI. Isolation: During the care of any . resident with known or suspected COVID-19, healthcare personnel should do the following: . Wear a N95 mask upon entering the resident's room or when working within 3 feet of the resident . The following document was provided by the Administrator when he/she was asked for a policy regarding [MEDICATION NAME] care visitation. Review of document titled, [MEDICATION NAME] Care Amidst the COVID-19 Crisis written by the American Health Care Association and National Center for Assisted Living, did not address the process of allowing visitation of family members/friends with a COVID+ resident at the end of life. In an interview on [DATE] at 11:45 AM, the Administrator said, This (the above document) is what we are following. A second document provided by the Administrator regarding visitation and wearing of PPE, Frequently Asked Questions (FAQs) on Nursing Home Visitation dated [DATE], stated, . 2. The reopening recommendations maintain that visitation should only be allowed for [MEDICATION NAME] care situations . CMS cannot define each situation that may constitute a [MEDICATION NAME] care situation . We also remind facilities and visitors that all actions to prevent the transmission of COVID-19 should be taken when these visits are allowed. These actions include screening all visitors for symptoms of COVID-19, [MEDICATION NAME] social distancing, performing hand hygiene (e.g., use alcohol-based hand rub upon entry) and both residents and visitors wearing a cloth face covering or facemask for the duration of their visit. In an interview on [DATE] at 12:00 PM, The administrator stated, I reached out, and this was all he/she had and there was not a policy or procedure addressing what PPE a visitor should wear during a [MEDICATION NAME] care visit with a COVID-19 positive resident. A telephone interview on [DATE] at 3:43 PM with Licensed Practical Nurse (LPN) #5, the LPN that was working on the nights/mornings when Resident #1 and Resident #3 died , stated Resident #1's family members were contacted the morning of her death and said that they would come in to visit her. LPN#5 said that he/she could not remember anything else about Resident #1's family's visit. LPN#5 stated that Resident #3's daughter visited Resident #3 the morning of his/her death and was certain the daughter wore PPE (mask, gown, gloves) the entire visit. An interview was attempted via telephone on [DATE] at 1:55 PM with Certified Nursing Assistant (CNA) #1 (worked 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** - Many | (continued... from page 1)<br>shift when Resident #1 died ), but there was no answer. In an interview on [DATE] at 8:10 PM, with Family member #1, who was also the named responsible party for Resident #1, he/she described the visit with his/her mother and how he/she found out his/her mother was COVID-19 positive. Family member #1 said that he/she received a call from the facility early on Monday morning and was told that Resident #1 was not doing well. Family member #1 and three additional family members came to visit Resident #1 that morning and stayed about one hour. Family member #1 said that his/her sister stayed with Resident #1 for the entire hour. Family member #1 stated, later the same day, the undertaker called him/her and asked him/her if he/she knew Resident #1 had COVID. Family member #1 stated, They never told us that she was positive. Family member #1 said that the facility staff did not screen them upon entering the facility and did not offer any PPE (masks, gloves, gown) for the family to wear during the visit. In an interview on [DATE] at 8:34 PM, Family member #2 (of Resident #1), said that upon entrance to the facility, the facility staff did not screen the family members. Family member #2 said that he/she was wearing his/her own mask, but the facility staff did not offer any additional PPE. Family member #2 stated that during the visit the staff never told the family about Resident #1's COVID positive status. Family member #2 stated about three or four weeks ago they did receive a phone call from the facility explaining that there was an outbreak (COVID-19) and Resident #1 was negative and had been separated from the positive residents. Family member #2 said that during the visit the staff had masks on, only. A review of the facility's COVID-19 screening and signature sheets for the dates [DATE], [DATE] , [DATE], and [DATE] showed the family members who visited Resident #1 and Resident #3 had not signed in as confirmation that they received the entrance screening for signs and symptoms of COVID-19. |
| F 0885<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, policy review, and interview the facility failed to: 1.) Ensure that the responsible party was notified for one of three sampled residents (Resident #1, Resident#3 and Resident#4) of COVID-19 testing status by 5:00 PM the following day after results were received. 2.) Ensure [MEDICATION NAME] care visitors for two of three sampled residents (Resident #1 and Resident #3) were screened prior to entry to the facility. As a result of these failures, five visiting family members could have been exposed to COVID-19 without their knowledge and could have potentially had signs or symptoms of COVID-19 which had the potential to spread the infection to other residents and staff due to lack of screening upon entry. Findings include: A review of Resident #1's Face Sheet found in the electronic medical record (EMR) under the Admissions Tab indicated the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #1's Progress Notes found in the EMR under the Progress Notes Tab indicated: on [DATE] at 3:24 AM, Patient C-19+, precautions continued; on [DATE] at 2:28 AM, Patient C-19+; precautions continued.; on [DATE] at 4:31 AM, abnormal vital signs were noted and contact was made with Resident #1's Responsible Party who stated they would come in and see Resident #1 at the facility. Resident #1 died on [DATE] at 9:30 AM. A review of Resident #1's Lab Test Results found in the EMR under the Resident Records Tab indicated on [DATE] and [DATE] Resident #1 tested positive for COVID-19. A review of Resident #3's Face Sheet found in the EMR under the Admissions Tab indicated the facility admitted Resident #3 on [DATE] with the [DIAGNOSES REDACTED]. A review of Resident #3's Lab Test Result found in the EMR under the Resident Records Tab indicated on [DATE] Resident #3 tested positive for COVID-19. A review of Resident #3's Progress Notes found in the electronic medical record (EMR) under the Progress Notes Tab indicated: on [DATE], C-19+; precautions continued.; on [DATE], Patient is hospice with COVID.; on [DATE] at 9:29 AM, Daughter .at bed side; resident has 0 respirations and pulse. Resident #3 died on [DATE]. A review of Resident #4's Face Sheet found in the EMR under the Admissions Tab indicated the facility admitted Resident #4 on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #4's Lab Test Result found in the EMR under the Resident Documents Tab, indicated on [DATE] Resident #4 tested positive for COVID-19. In an interview on [DATE] at 2:15 PM with the Interim Director of Nursing (IDON), it was confirmed there was no documented evidence the facility staff notified the family members/responsible party of Resident #1's, Resident #3's and Resident #4's positive COVID-19 status. In an interview on [DATE] at 2:30 PM with the IDON, he/she confirmed that Residents #1 and #3 were residing on Level 1 (the COVID positive unit) at the time of their deaths. A review of the facility's COVID-19 screening and signature sheets for the dates of [DATE], [DATE], [DATE], and [DATE] showed the family members who visited Resident #1 and Resident #3 had not signed in as confirmation they received the entrance screening for signs and symptoms of COVID-19. Review of the facility's policy, Coronavirus (COVID-19) Infection Prevention and Control Practices Policy, revised [DATE] stated, Policy Statement: It is the policy of the (name deleted) organization to initiate the appropriate measures to protect our patients/residents, partners and families from risks associated with the Coronavirus (COVID-19) through mitigation and educational tools, utilizing resources as provided by the Department of Public Health and Centers for Disease Control . II. Screening of Partners, Visitors and Vendors 1. All locations are required to setup screening stations at the main entrance to screen . visitors for the following: Travel to area where there are ongoing outbreaks of COVID-19, Contact with someone who has or is suspected to have COVID-19, Fever, Cough, Shortness of Breath, Sore Throat, Fatigue, Chills, Sweats. 2. The screening station should include the following supplies: Alcohol Dispenser (at least 60%), Gloves, Germicidal Wipes, Procedure Masks . Review of the document titled, [MEDICATION NAME] Care Amidst the COVID-19 Crisis written by the American Health Care Association and National Center for Assisted Living, undated, showed the document did not address the process of visitation of family members/friends with a COVID+ resident at the end of life. This document was provided by the Administrator when he/she was asked for a policy regarding [MEDICATION NAME] care visitation. In an interview on [DATE] at 11:45 AM, the Administrator said, This (the document) is what we are following. In an interview on [DATE] at 8:10 PM, family member #1 (Resident #1's responsible party) said that he/she received a call from the facility early on Monday morning and was told that Resident #1 was not doing well. Family member #1 said he/she and 3 additional family members came to visit Resident #1 that morning and stayed for about one hour. Family member #1 said his/her sister stayed with Resident #1 for the entire hour. Family member #1 stated, later the same day, the undertaker called him/her and asked him/her if he/she knew Resident #1 had COVID. Family member #1 stated, They never told us that she was positive. Family member #1 said that the facility staff did not screen them upon entering the facility and did not offer any PPE (masks, gloves, gown) for the family to wear during the visit. In an interview on [DATE] at 8:34 PM, family member #2 (for Resident #1), said that upon entrance to the facility, the facility staff did not screen the family members. Family member #2 said he/she was wearing his/her own mask, but the facility staff did not offer any additional PPE. Family member #2 said that during the visit the staff had masks on, only. Family member #2 stated that during the visit the staff did not inform the family of Resident #1's positive COVID status. Family member #2 stated about three or four weeks ago the family received a phone call from the facility explaining that there was an outbreak (COVID-19) and Resident #1 was negative and had been separated from the positive residents. |