STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425008	A. BUILDING _____ B. WING _____	04/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND OF COLUMBIA REHAB AND NURSING CENTER	2601 FOREST DRIVE COLUMBIA, SC 29204

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 **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, staff interviews, the facility's policy entitled COVID-19 Policy/Plan for Facilities, record review, and review of staff screening logs, the facility failed to: 1) provide appropriate screening for one (1) of one (1) staff member and two (2) of two (2) transporters; 2) ensure isolation carts were stocked with personal protective equipment for three (3) of three (3) carts observed; 3) ensure one (1) of one (1) staff member (Employee #1) washed their hands when they entered and exited resident rooms to prevent the spread of infection; 4) ensure staff were aware of isolation precautions for one (1) of four (4) residents (Resident # 4); and 5) ensure six (6) of 43 residents remained six (6) feet apart and practiced social distancing. The finding included: 1. During an observation on 4/21/20 at 9:35 a.m., Employee #6 entered the facility without being screened. Employee #2 was responsible for screening visitors and staff. Two (2) ambulance employees (Transporter #1 and #2), came into the facility to transport a resident to an appointment. Employee #2 did not take either of the transporter's temperature and did not record answers to the screening questions. Transporter #1 requested his temperature be taken. There was no thermometers available to test temperatures. When a thermometer was provided, Employee #2 was unaware of how to operate the device. A review of the facility's COVID-19 Sign In/Out Log Form, for the above observations, revealed Employee #6 member's name, but no screening or temperature was recorded. In additon, the federal surveyor was not screened per the facility policy and CDC recommendations when she entered the facility. Review of the facility policy updated 3/28/20 entitled, COVID-19 Policy/Plan for Facilities revealed, Temperatures of staff will be taken with no person permitted to work with a temperature greater than 99.0. All staff will complete the Staff Log and be screened for potential concerns prior to reporting to resident areas. Staff logs now include temperatures at exit as well. During an interview with the Administrator and Director of Nursing (DON) on 4/21/20 at 1:00 p.m., the DON communicated staff had been trained to complete the screening questions and have their temperature taken every time they came into the facility. She said she expected the screening to be completed as required. 2. During the initial tour of facility on 4/21/20 at 10:03 a.m., Resident #'s 1, 2, and 3 doors were open. An isolation cart was outside each of the resident's rooms. The carts contained a stethescope and gloves. The cart outside Resident #1's room, also contained gowns. No additional personal protective equipment (PPE) was in the carts. There was a sign that read, See Nurse before entering room on the doors, but no signage indicating PPE should be worn in the room. Review of the medical records for Resident #'s 1, 2 and 3 revealed they were each on Contact Isolation. During an interview with the Infection Control (IC) Nurse on 4/21/20 at 10:35 a.m., she stated all isolation room doors should be kept closed, and all necessary PPE should be stored in the isolation carts. The IC Nurse indicated all residents that returned from a hospital stay were placed on droplet precautions. She further stated PPE was available and should be worn when caring for Resident #'s 1, 2, and 3. She added, the carts should have contained the necessary items. During an interview with the DON and the Administrator on 4/21/20 at 12:38 p.m., the DON said staff had been trained on isolation procedures. The DON indicated each resident on isolation precautions should have PPE outside their rooms and staff should wear the required items. 3. During an observation on the 200 front hallway on 4/21/20 at 11:35 a.m., Employee #1 entered Resident #1's room with a food tray. Employee #1 entered the room wearing only a mask. She repositioned Resident #1's bedside table using her bare hands, and placed the resident's meal tray on the table. She did not wash or sanitize her hands before or after she touched the table or before she left the room. She was observed delivering meal trays to seven (7) rooms. She did not wash/sanitize her hands before she entered or exited the rooms, or before she went into the next room to prevent the spread of infection. During an interview with the DON and the Administrator on 4/21/20 at 12:38 p.m., the DON said staff members were trained on the isolation procedures as well as handwashing procedures. The DON communicated she expected employess to wash and/or sanitize their hands. 4. Resident #4 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During the tour of the Patient Under Investigation Unit (PUIU), on 4/21/20 at 11:15 a.m., an isolation cart was observed outside Resident #4's room. The cart contained a stethoscope and gowns in the top drawer and gloves on top of the cart. There was no other PPE in the cart. Employee #3 was observed entering and exiting Resident #4's room without wearing PPE. During an interview with Employee #3 on 11/21/20 at 11:20 a.m., the employee stated she was unsure what PPE was required when entering the resident's room and would need to follow up with the nurse. During an interview the charge nurse on the PUIU on 11/21/20 at 11:25 a.m., she stated she was unsure of the type PPE required for Resident #4 and would need to follow up. Failure to follow isolation precautions increases the risk of the spread of infection. During an interview with the DON and the Administrator on 4/21/20 at 12:38 p.m., the DON said staff should be aware of the isolation procedures for all residents. She further communicated the unit nurses should communicate with other staff members about resident specific requirements for PPE and the requirements should be followed. 5. During an observation on the first floor back unit at 4/21/20 at 10:50 a.m., six (6) residents were observed sitting approximately two to three feet apart from each other watching a television program. The residents did not wear a face mask, and did not perform hand hygiene after they touched chairs and tables in the room, which increased the risk for the spread of infection. During an interview with Employee #5 on 4/21/20 at 11:01 a.m., she confirmed the residents were sitting too close together, and the residents should practice social distancing. She further stated residents should have worn a mask when they were outside of their rooms. Review of the facility's educational training material revealed nursing staff members had been provided education related to Infection Control. Further review of the training material revealed residents could come out of their rooms, but should practice social distancing and remain six (6) feet apart, according to the guidance from the Centers for Disease Control. During an interview with the DON and Administrator on 4/21/20 at 1:20 p.m., revealed they were unaware staff were allowing residents to sit together in the television room area.

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.