STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425288	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH- RIDGEWAY	**213 TANGLEWOOD COURT RIDGEWAY, SC 29130**

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.** Based on observations, interviews, record review and facility policy review, the facility failed to properly prevent potential exposure and transmission of COVID-19 by: 1. Failing to ensure visitors were thoroughly screened upon entrance for 2 of 2 visitors observed; 2. Failing to maintain six-foot social distancing between 2 of 2 visitors observed with 1 (Admissions Director #11) of 1 staff member; 3. Failing to ensure proper hand hygiene was performed during tray pass and touching of ready to eat foods, which affected 3 of 13 residents on the 200 hall. This deficient practice had the potential to affect all residents and occurred during the COVID-19 pandemic. The facility census was 109. Findings included: 1. On 09/23/20 at 2:40 PM, the Admissions Director (AD) #11 was observed meeting with two visitors at a table in the facility's main lobby. The table was approximately two feet in diameter. The Admissions Director and the two visitors were wearing face coverings and sitting close to the table. The visitors were wearing cloth face coverings. On 09/23/20 at 2:45 PM, the AD was interviewed. AD #11 stated admission paperwork was always completed at the two-foot table in the lobby and s/he had not even considered that they were not social distancing. On 09/23/20 at 2:50 PM, Registered Nurse (RN) Nurse Navigator #6 was observed meeting with two visitors at a table in the facility's main lobby. The table was approximately two feet in diameter. RN Nurse Navigator #6 and the two visitors were wearing face coverings and sitting close to the table. The visitors were wearing cloth face coverings. On 09/23/20 at 3:05 PM, the Infection Control (IC) RN was interviewed. IC RN #3 stated it was in the facility's policy to maintain six-foot social distancing. RN IC #3 nurse observed and agreed the two visitors in the front lobby were not maintaining social distancing, therefore not meeting infection control guidelines. 2. The facility's policy titled, Coronavirus (COVID-19) Infection Prevention and Control Practices Policy, dated 03/06/20 documented, in part: Section II. Screening of Partners, Visitors and Vendors 1. All locations are required to set up screening stations at the main entrance to screen partners, vendors and visitors for the following: Travel to area where there are ongoing outbreaks of COVID-19; fever. 3. Should any visitor or vendor present with all the above risk factors, a mask will be provided and access to the location will be denied. On 09/23/20 at 2:53 PM, the visitor screening form was reviewed. The visitor screening form revealed the first visitor did not fill in the line designated for temperature and answered 'yes' to having visited the South Carolina beaches. The second visitor screening form answered 'yes' to having visited the South Carolina beaches. On 09/23/20 at 3:05 PM, the Infection Control (IC) RN was interviewed. IC RN #3 stated the facility had not started in facility visitors. S/he added the facility's policy was to obtain approval from someone in a management position if a visitor wanted to enter the facility and had triggered for visiting a South Carolina beach. Once approved to enter the facility, the visitor was supposed to be given a KN95 mask to wear. RN IC #3 nurse observed and agreed the two visitors in the front lobby were not wearing KN95 masks, therefore not meeting infection control guidelines. On 09/23/20 at 3:20 PM, RN Nurse Navigator #6 was interviewed. S/he stated s/he was the person who had screened the visitors and did not review the screening form. S/he did not know that it was the policy to obtain approval from higher management to allow visitors in from a South Carolina beach town. S/he also did not know the visitors were supposed to wear KN95 masks. On 09/23/20 at 3:37 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA stated the facility had trained on the policies related to screening and allowing visitors and was disappointed to see the policy and CDC guidelines were not being followed. The facility's policy titled, Coronavirus (COVID-19) Infection Prevention and Control Practices Policy, dated 03/06/20 documented, in part: Section II. Screening of Partners, Visitors and Vendors 1. All locations are required to set up screening stations at the main entrance to screen partners, vendors and visitors for the following: Travel to area where there are ongoing outbreaks of COVID-19; fever. 3. Should any visitor or vendor present with all the above risk factors, a mask will be provided and access to the location will be denied. 3. On 09/22/20 at 12:15 PM, lunchtime tray pass was observed. Certified Nursing Assistant (CNA) #10 donned a pair of gloves and passed a lunch tray. S/he returned to the meal cart, took off her gloves and without washing or sanitizing her hands, s/he donned a new pair of gloves. With her/his gloved hands, CNA #10 touched the meal cart, a food tray, knocked on the resident's room door, rearranged items on the resident's bedside table and then placed the tray on the bedside table. With the same gloved hands, CNA #10 removed a bread roll from a bag and the placed it on the tray with her/his gloved hands. CNA #10 returned to the meal cart and with the same gloved hands, removed another tray, knocked on another resident's room door and proceeded to place the tray on the resident's bedside table. CNA #10 removed the bread roll from the bag, with her/his gloved hand and placed it on the resident's tray. Without removing her gloves, washing and/or sanitizing her hands, CNA #10 returned to the meal cart to remove another tray from the cart and deliver it to a third resident. CNA #10 was observed removing the bread roll with her gloved hands and placing it on the resident's tray. On 09/22/20 at 12:27 PM, CNA #10 was interviewed. CNA #10 stated s/he knew it was not appropriate to touch ready to eat food with bare and/or gloved hands. CNA #10 stated she did not sanitize her/his hands in between meal tray passes because, no way to sanitize if I don't have it. On 09/22/20 at 12:33 PM, the Registered Nurse for Infection Control (RN IC) #3 was interviewed. RN IC observed CNA #10 passing the lunch trays and stated s/he had, a lot of re-training to do.

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.