

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 425117	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2020
NAME OF PROVIDER OF SUPPLIER CARLYLE SENIOR CARE OF KINGSTREE		STREET ADDRESS, CITY, STATE, ZIP 401 NELSON BOULEVARD KINGSTREE, SC 29556	
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	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observations, interview, and policy review, the facility staff failed to wear all required personal protective equipment when on the Coronavirus (COVID) 19 unit. This failure had the potential to affect all 16 residents, with confirmed or suspected [DIAGNOSES REDACTED].#1, #2, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17). Findings Include: 1. Review of facility policy titled: Novel Coronavirus Prevention and Response, Approval and Effective date: 3/26/2020, revealed the facility would respond promptly upon suspicion of illness associated with a Novel Coronavirus in efforts to identify, treat and prevent the spread of [MEDICAL CONDITION]. The definition per the facility policy was: COVID-19 is a new respiratory disease caused by a novel (new) Coronavirus that is spread person-to-person, mainly between people who are within six (6) feet of one another through respiratory droplets produced when an infected person coughs or sneezes. According to the policy, the Infection Preventionist would assess facility risk associated with COVID -19 through surveillance activities of emerging diseases in the community and illness present in the facility. The facility procedure when COVID-19 was suspected was: Implement standard, contact and airborne precautions (droplet precautions if no airborne isolation room available). Wear gloves, gowns, goggles/face shields and masks (respirators) upon entering room and when caring for the resident. 2. Review of Facility's Training, dated 4/2020, revealed annual training for infection control including proper (PPE) personal protective equipment was completed by all staff members. 3. Observation on 6/16/2020 at 9:00 a.m. on the COVID-19 isolation unit, revealed, Unit Charge License Practical Nurse (LPN) #3 was observed exiting a resident's room without the required N95 or surgical mask. The nurse was observed to have on a cloth mask. The nurse wore the rest of the required PPE in accordance with the policy. Interview on 6/16/2020 at approximately 9:06 a.m. with License Practical Nurse (LPN) #3, revealed he/she was responsible for administering medications to all 16 residents on the COVID-19 unit. When queried about required personal protective equipment, the LPN stated he/she received training but decided to wear her own mask today. 4. Observation on 6/16/2020 at approximately 9:47 a.m. revealed Certified Nursing Assistant (CNA) #4 exited a resident's room on the COVID-19 isolation unit without the required face shield or goggles. The CNA wore the rest of the required PPE in accordance with the policy. Interview on 6/16/2020 at 9:48 a.m. with CNA #4, revealed I received training on the use of wearing the required personal protective equipment, but I don't like to wear the shield or the googles because they make me hot and fog up. 5. Interview on 6/16/2020 at approximately 11:00 a.m. with Director of Nursing/Infection Control Nurse, revealed all staff members had been trained on how to use the proper personal protective equipment on the COVID-19 unit. He/she stated, all staff received annual training related to infection control in February of this year and that his/her expectation was for all staff to wear the required personal protective (PPE) equipment upon entering any resident's room, especially on the COVID-19 unit.</p>		

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.