STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425316	A. BUILDING _____ B. WING _____	**09/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN AGE INMAN	**82 N MAIN STREET INMAN, SC 29349**

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 -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility policy review, the facility failed to implement protocols for use of Personal Protective Equipment (PPE) and handwashing for Standard, Contact and Droplet Precautions in residents' rooms and in the residents' dining room. In addition, the facility failed to perform adequate sanitary environmental cleaning in the residents' rooms and in the dining room during meals. These failures affected all 33 residents residing in the facility, creating the potential for transmission of coronavirus (COVID)-19. Findings include: The policy titled, Infection Control Overview & Policy, undated, indicated: The purpose of this Infection Control Program .is to: (1) Investigate, control, and prevent infections in the facility; (2) Communicate the environmental and/or dining services procedures that should be applied in the field; .(4) To comply with centers for Medicare and Medicaid Services (CMS) guidelines in relation to CMS F880 tag found in CFR 483.80(a)(1)(2)(i)-(iii)(v)-(vi)(e). In addition to this program, it is important that all infection prevention and control practices reflect current Centers for Disease Control (CDC) guidelines .Preventing Spread of Infection .Prevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions; Implement hand hygiene (hand washing) practices consistent with accepted standards of practice .(1) (Use) proper .personal protective equipment when. delivering food to a resident in isolation .Infections and diseases are transmitted in several ways including: A. Airborne .B. Contact with an infected object, person or surface (touching); C. Droplet (when someone coughs, sneezes, or talks) .B .Contact precautions require the use of appropriate PPE, including a gown and gloves upon entering the contact precaution room .Environmental Services Employees .1. Use effective quaternary germicidal solution along with systemic cleaning of all resident rooms. The facility provided the policy titled, Interim Recommendations for Terminal COVID-19 Isolation Room/Unit Cleaning, dated 5/20/2020 which directed: .steps involved in cleaning a COVID-19 isolation room . include: 7. Knowing the timing and method of cleaning reusable materials .It is highly important that we use an EPA (Environmental Protection Agency) approved solution for .cleaning isolation rooms to ensure the product in use is effective against the specific germ .C. (use) an EPA approved solution according to manufacturer specifications .(EPA List N). Be sure to follow the manufacturer's recommended dwell time .contact time . 1. According to epa.gov, The EPA expects all products on List N to kill the coronavirus [DIAGNOSES REDACTED] (Severe Acute Respiratory Syndrome)-CoV-2 (COVID-19) when used according to the label directions. According to List N: Disinfectants for Use Against [DIAGNOSES REDACTED]-CoV-2 (COVID-19) all products on this list meet the EPA's criteria for use against [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] that causes COVID-19. The product Virex Tb, Ready-To-Use revealed a contact time (on the surface) for two (2) minutes was required. During interview on 9/23/2020 at 1:48 p.m., Housekeeping staff (HK) #1 stated s/he used Virex for daily cleaning and for deep cleaning the rooms. S/he stated s/he sprayed it on and then wiped it dry. S/he stated, You don't really have to leave it on at all; you can just wipe it off right away. HK #1 exhibited the Virex Tb, Ready-To-Use product used by HK staff; the label directed, Contact time (leave product wet) for two (2) minutes. During interview on 9/24/2020 at 11:57 a.m., the Maintenance Supervisor (MS) stated s/he was filling in for the Housekeeping Supervisor. The MS stated s/he provided instruction for the staff for PPE use and completed the N-95 mask fit testing for all staff in the event of a Covid case. The MS stated for the daily cleaning of Transmission-Based Precautions (TBP) rooms, the Housekeeping staff should wear appropriate PPE including a mask, gloves, face shields/goggles, gown and foot coverings; the foot coverings were available in the front office, and face shields were available in the HK carts. The MS stated s/he was not familiar with the directions on the Virex bottle label stating, I would expect; you would think they (HK staff) would know (the label directions). The whole purpose of the stuff (Virex) is that it kills everything. 2. During interview on 9/23/2020 at approximately 10:00 a.m., the Administrator stated the facility did not have any Covid positive cases but had four (4) residents in 14-day quarantine because they were new admissions or had been out of the building on appointments. The four (4) rooms listed by the Administrator for transmission based precautions (TBP): Rooms 102, 106, 108 and 110. Observation revealed four (4) rooms with two (2) TBP signs on the doors: Room #s 102, 106, 108 and 110. The sign posted on the doors for Contact Precautions directed, STOP. Everyone Must: Clean their hands, including before entering and when leaving the room .Put on gloves before room entry . Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit . The sign for Droplet Precautions directed, STOP. Everyone Must: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry (picture of a face shield or goggles); Remove face protection before room exit. During interview on 9/23/2020 at 1:55 p.m., Licensed Practical Nurse (LPN) #1 stated the facility had no positive Covid cases; however, four (4) residents were in quarantine at this time because they were new admissions or had been outside the facility to appointments. LPN #1 stated the four (4) quarantine rooms had signs so staff knew what type of TBP were in place, and which PPE staff should wear in the room. LPN #1 stated the quarantine rooms had signs for both Contact Precautions and Droplet Precautions, and staff should wear a gown, gloves, a mask and eye protection - goggles or a face shield. LPN #1 stated s/he wore glasses, so did not need extra eye protection. During interview on 9/24/2020 at 11:40 a.m. LPN #2 stated the night shift cleaned the medication cart because the cleaning products were kept in the medication room which was near where they kept the carts at night. LPN #2 further stated residents were kept in quarantine precautions after they went out for an appointment or were new admissions. At approximately 11:43 a.m., LPN #2 entered Resident #5's room (room [ROOM NUMBER]) which was posted with two (2) bright green signs for Contact Precautions and Droplet Precautions only wearing a surgical mask. Observation from the doorway revealed the LPN wearing only a surgical mask inside the room. LPN #2 did not wear a clean mask, gloves or a gown and assisted the resident to button his/her pants. After exiting the room, LPN #2 stated s/he wore gloves to assist the resident and washed his/her hands afterwards. This was not observed. LPN #2 stated s/he knew if a resident was on TBP because there would be a PPE cart near the door or hanging on the door. LPN #2 stated, Housekeeping must have moved the cart; it's not here. LPN #2 further stated, I'm not sure of the difference between quarantine and isolation and precautions. LPN #2 stated s/he judged the isolation precautions based on the cart containing PPE and did not notice the sign on the door. LPN #2 stated, I'm sorry about not removing the mask (before leaving the room); I'll remove it now. When asked about the Contact and Droplet Precautions signs, LPN #2 stated, I helped (the resident) buckle (his/her) pants; I did wear gloves, and I washed my hands before I left the room. I have a mask on, and I did not see the sign about the gown, and I did not remove my mask before leaving the room. It's a good question about the eye protection; I have not seen it here; I have never seen the eye protectors here. During a follow-up interview on 9/24/2020 at 1:24 p.m., LPN #2 stated s/he learned that the eye protection was used only for a resident who tested positive for Covid. LPN #2 stated s/he thought quarantine meant the resident should stay in their room and staff should wear a mask, but the resident wasn't on droplet precautions since they weren't Covid positive residents , despite the Droplet Precaution sign on the door. 3. Observation on 9/24/2020 from 12:36 p.m. to 1:23 p.m. in the residents' dining room revealed eight (8) residents eating at separate tables with one (1) resident per table. The tables and residents were spaced at least six (6) feet apart. When a resident finished the meal, another resident took their turn after the table was cleaned and sat at the table. Observations included: - 12: 36

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** - Many	(continued... from page 1) p.m.: A resident touched his/her straw and picked up his/her fork, then set down the fork. Certified Nursing Assistant (CNA) #1 picked up the fork with bare hands, cut the resident's spaghetti, and set the fork on the resident's plate. CNA #1 did not clean his/her hands before or after touching the resident's fork; the CNA then donned gloves without first washing his/her hands. - 12:37 p.m. CNA #2 picked up a resident's used cup and packaging following the meal, placed the items in the trash and dirty dish area, did not wash hands, and then donned gloves. At 12:40 p.m. wearing the same gloves, CNA #2 cleaned a resident's table, touched his/her own hair and cleaned another resident's table. -12:42 p.m. CNA #2's mask fell below his/her nose. CNA #2 continued to pull a table into position, went to a plastic storage box and pulled open a drawer, removed a used resident's cup and placed it in the dirty dish area, and pushed a resident's wheelchair out to the hall. -At 12:43 p.m., CNA #2 pulled his/her mask up over his/her nose, then returned and cleaned a table, continuously wearing the same gloves with unwashed hands. CNA #2 delivered a tray of food to a resident, then removed his/her gloves and sanitized his/her hands. CNA #2 did not don new gloves and cleared used dishes and moved a resident in a wheelchair to the door. Then CNA #2 pulled up his/her own mask to cover the nose on the outside of the mask. - 12:45 p.m., two (2) residents entered to eat and staff did not offer to clean their hands before the meal. - 12:52 p.m. CNA #2 cleaned his/her hands, cleared used resident dishes, did not wash hands, donned new gloves, touched and pulled up his/her mask, then sanitized a table. - 12:54 p.m., CNA #2's mask fell under the nose; he/she moved it into place at 12:55 p.m. touching the outside of the mask and did not clean his/her hands. - 1:00 p.m., CNA #2 pulled the outside of the mask up over his/her nose and did not clean hands while s/he sat across the table with a resident who was eating. -At 1:06 p.m. CNA #2 picked up and handed a napkin to a resident without cleaning his/her hands first. - 1:08 p.m. CNA #2 pulled the outside of the mask up over his/her nose. During a conversation with another staff, the mask slipped down below the nose again as s/he continued to sit at the table with a resident eating. -At 1:10 p.m., CNA #2 brought two (2) napkins out of a plastic storage drawer, handed them to a resident, but the CNA had not cleaned his/her hands first. CNA #2 then pulled up the outside of the mask again over his/her nose. -At 1:12 p.m., CNA #2's mask slipped under the nose again and s/he pulled it up on the outside of the mask; then got a spoon out of the drawer, gave it to the resident, and pulled up the mask again. -At 1:13 p.m., the resident picked up and used the spoon given to her/him by CNA #2. -1:14 p.m., CNA #2 pulled up the mask again. -At 1:15 p.m., CNA #2 donned gloves without first washing his/her hands, cleared dishes, and rubbed his/her right shoulder. -At 1:16 p.m., CNA #2 removed gloves and sanitized his/her hands. CNA #2 had not cleaned his/her hands since 12:53 p.m. - 1:17 p.m., CNA #2 pulled the mask over the nose without cleaning his/her hands while sitting again at a resident's table. - 1:19 p.m., CNA #2 pulled the mask over the nose without cleaning his/her hands while sitting again at a resident's table. - 1:20 p.m., CNA #2 pulled down his/her mask with bare hands and scratched the side of his/her right eye, then pulled up the mask again without cleaning his/her hands. - 1:21 p.m., CNA #2 poured tea into a Styrofoam cup, pushed the lid down and unwrapped a straw, put it in the cup and handed it to a resident. CNA #2 had not cleaned his/her hands since 1:16 p.m. - 1:22 p.m., CNA #2 pulled the mask over the nose without cleaning his/her hands again. During interview on 9/24/2020 at 1:42 p.m., CNA #2 stated they sanitized the tables in the dining room after each resident finished and left the tables wet for 10 minutes. CNA #2 stated staff should always offer to clean the resident's hands before a meal, and staff should always wear a mask covering the nose and mouth. CNA #2 further stated s/he should have sanitized his/her hands between each task in the dining room and should not have touched herself or the outside of the mask without cleaning hands and donning gloves. CNA #2 stated, I have trouble keeping the mask up and not slipping down, and I know I had to adjust it again right now (during the interview). During interview on 9/24/2020 at 2:58 p.m., CNA #1 stated staff was supposed to wash hands before and after touching items the residents touched. CNA #1 agreed s/he did cut up a resident's spaghetti, but denied she failed to wash hands before and after touching the resident's fork. Handwashing was not observed before or after CNA #1 touched the resident's fork. 4. Observation on 9/24/2020 at 5:41 p.m. revealed CNA #1 entered room [ROOM NUMBER] with two (2) plastic grocery bags wearing only a mask and handed the bags to the resident. At 5:42 p.m., CNA #1 stated she did not wear the proper PPE because the resident had Contact and Droplet Precautions signs on the door, and stated, I wiped off the bags, and only handed them to (the resident). Observation on 9/24/2020 from 5:42 to 5:45 p.m. revealed CNA #3 delivered room trays to Rooms 106, 108 and 110 which were rooms with signs for Contact and Droplet precautions. CNA #3 had on a mask and gown, no gloves and did not change the PPE or clean his/her hands between rooms. During interview at 5:50 p.m., CNA #3 stated, I was supposed to put PPE on and change between each room, but I did have my hands kind of full. CNA #3 stated s/he did have PPE and TBP education and should have followed the same PPE guidelines for quarantine as for the precautions. CNA #3 further stated, We should only change our gown and gloves between rooms I think; I'm sorry, they didn't tell us if we should change our masks or wear gloves to pass trays. During interview on 9/24/2020 at 6:03 p.m., LPN #3 stated for quarantine residents, they were on Contact and Droplet Precautions and the PPE worn should include a mask, gown and gloves; staff should always leave the PPE in the room and put on new PPE between rooms. S/he stated if staff was delivering trays and not touching anything in the room, they should clean their hands and change their gloves between resident rooms. During interview on 9/25/2020 at 12:47 p.m., the Director of Nursing (DON) stated LPN #2 should have worn a mask, gown and gloves when going into the room, and changed out of them before leaving the room, especially after hands-on care. The DON stated the staff were educated to wear eye protection only for care involving splashing, or a positive Covid case. The DON further stated that s/he had to re-educate staff about the differences between isolation and quarantine, because they were the same thing. The DON agreed staff was still confused about the differences, and when to wear which PPE. The DON agreed staff should never adjust the mask by the front of the mask and should use handwashing and gloves when serving in the dining room between tasks. S/he stated staff should wear a mask, gown and gloves between rooms when serving meals in quarantine rooms, and wash hands and change gloves between rooms if the only thing touched was the resident's tray. During interview on 9/25/2020 at 4:20 p.m., the Administrator stated nursing staff should follow the education they had been given for PPE use according to the facility's policies and the CDC Guidelines, which their policies followed.