STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425121	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONWAY MANOR	3300 4TH AVENUE CONWAY, SC 29527

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 observation, interview and review of the facility policy, the facility failed to properly contain coronavirus (COVID)-19 for all 41 residents residing on the COVID Isolation /Locked Memory Care Unit. Failures on the COVID Isolation/Locked Memory Care Unit included: one (1) staff did not perform appropriate hand hygiene before retrieving ice for Resident #4; one (1) staff did not put on a gown before entering Resident #5's room per facility policy; and reusable gowns were being worn by different staff without cleaning in between use. On the facility's COVID-19 Isolation/Locked Memory Care Unit, there were 23 residents that had tested positive for COVID-19. Findings include: 1. Review of the facility's documentation on the Census List indicated that Resident #4 had tested positive for COVID-19 on 7/15/2020. During the observation on 8/3/2020 from 10:30 a.m. to 11:00 a.m., Certified Nursing Assistant (CNA) #1 was passing ice to the residents on the 500 Wing (where residents that had been tested positive for COVID-19 resided). The CNA removed her/his gloves inside Resident #4's room and brought the resident's mug out of the room to the ice chest to put ice in it. The CNA touched the resident's privacy curtain prior to retrieving the resident's mug. The CNA exited the room, then put on gloves in the corridor standing by the ice chest without first cleaning her/his hands. The CNA used a Styrofoam cup to scoop the ice out of the ice chest. The CNA's gloved fingers that were around the Styrofoam cup could be seen touching the ice in the ice chest. During an interview on 8/3/2020 at 10:40 a.m., CNA #1 indicated there was no scoop for the ice. In an interview on 8/3/2020 at 10:41 a.m., the ADON indicated the CNA should get a scoop from the kitchen and that all the ice in the ice chest would have to be thrown out. During the observation on 8/3/2020 from 10:30 a.m. to 11:00 a.m., the Assistant Director of Nursing (ADON) was overheard at 11:00 a.m. telling a CNA that the ice that was brought up to the exit of the 500 Wing was going to have to be thrown out. During an interview on 8/3/2020 at 4:00 p.m., the ADON indicated the ice in the ice chest was thrown out and the CNA was retrained. Review of the facility's policy with the reference 2001 Med-Pass, Inc. (Revised September 2010) indicated Putting on Sterile Gloves 1. Wash hands . Review of in-service training for CNA #1 revealed she/he had in-service training on handwashing, PPE and isolation precautions on 7/22/2020. 2. Review of the facility's documentation on the Census List indicated that Resident #5 had tested positive for COVID-19 on 7/15/2020. On 8/3/2020 at 10:46 a.m., CNA #2 was seen entering Resident #5's room. There were two (2) gowns hanging on the door of the room. The CNA was wearing a gown but did not put on one of the gowns hanging on the door. In an interview on 8/3/2020 at approximately 10:46 a.m., the ADON said CNA #2 should have put on a second gown before going into Resident #5's room. In an interview on 8/3/2020 at 10:30 a.m., the ADON said when the gowns became visibly soiled they were removed and washed; they were cloth gowns. The ADON stated the staff were to don the gown hanging on the door over their base gown (they wore continuously while they were on the COVID Unit) prior to entering the room. After finishing in the resident's room, they were to hang the used gown on the resident's door for other staff to wear until the gown was visibly soiled. In an interview on 8/3/2020 at 9:45 a.m. the Director of Nursing (DON) said the staff on the secure unit, where the residents who tested positive for COVID-19 resided, wore a gown, goggles and mask all the time. There was a second gown they were to don before going into a resident's room. The DON stated they took off the second gown after coming out of the room. In an interview on 8/3/2020 at 2:38 p.m. the DON indicated that staff on the secure unit wore the base gown all day and then if going into a room where a resident had tested positive, they were to put on a gown that was hanging on the door. When they were finished they were to hang up that gown for other staff to reuse. The DON indicated she/he had a copy of the CDC (Center for Disease Control) guidelines for reuse of gowns. In an interview on 8/3/2020 at 4:00 p.m., the DON said, It does not say you can or can't have more than one staff wear the gown. The DON indicated it was unclear whether there was risk involved for more than one staff to wear the same gown that had already been used by other staff. Review of the CDC guidance presented indicated it had been printed on 3/20/2020 with the following web address: www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html. The document indicated, Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP (health care professional) when interaction with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious [DIAGNOSES REDACTED]. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices .Cloth isolation gowns could potentially be untied and retied and could be considered for re-use without laundering in between .for care of patients with suspected or confirmed COVID-19, HCP risk from re-use of cloth isolation gowns without laundering among (1) single HCP caring for multiple patients using one gown or (2) among multiple HCP sharing one gown is unclear. The goal of this strategy is to minimize exposures to HCP and not necessarily prevent transmission between patients. Review of the facility's policy with the reference 2001 Med-Pass, Inc. (Revised September 2010) indicated .Reusable gowns shall be laundered after each use in accordance with established laundry procedures. Review of in-service training for CNA #2 indicated the CNA had Isolation Precautions and PPE (personal protective equipment) training on 6/16/2020.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE