STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted offsite from 6/1/20 through 6/3/20 and onsite and offsite from 6/8/20 through 6/11/20. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted offsite from 6/1/20 through 6/4/20 and onsite and offsite from 6/8/20 through 6/11/20. The facility was not in compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirements. The census in this 169 bed facility was 145 at the time of survey. Two new admissions were tested for COVID -19 prior to leaving the hospital, their results were negative. They are presently on isolation on the dementia care unit. Forty-Five residents were located on the isolation unit since three residents on the unit tested COVID 19 positive and are still hospitalized. Three staff have tested positive for COVID-19. They have not returned to work.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		7/1/20

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

Electronically Signed | 06/24/2020

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 880	Continued From page 1	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 2 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure infection control measures were consistently implemented to prevent the development and/or transmission of a communicable disease (COVID-19). The findings included: The facility staff failed to ensure social distancing and face coverings/masks were utilized among a group of five residents sitting and/or standing closely together near the nurses station. On 6/08/20 at approximately, 11:25 AM upon entrance onto a non-isolation unit, approximately five residents were observed sitting and standing at close contact near the nurses station. RN (Registered Nurse) #2 redirected the residents back to their rooms saying "it's time to eat lunch."	F 880	1. Residents provided face coverings/masks and repositioned to ensure social distancing maintained. 2. All residents have the potential to affected. In-house audit completed to ensure all residents have a face mask/covering by 6/24/2020. Newly admitted residents will be provided a face mask/covering upon admission and educated on social distancing. 3. Education on the infection control policy with an emphasis on face covering/mask along with social distancing for residents will be completed by the Staff Development Coordinator for all stakeholders to include documentation of resident refusals, education on risks,	

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F 880	Continued From page 3 On 6/09/20 at approximately 1:00 PM a telephone interview was conducted with CNA (Certified Nursing Assistant) #1. She stated, Resident's are "Only wearing masks if leaving off unit," and "When sitting at nurses' station, no mask are worn." On 6/09/20 at approximately 1:50 PM a telephone interview was conducted with CNA #2 She stated, "They only wear masks if leaving the floor." On 6/10/20 at approximately, 3:25 PM, an interview was conducted with RN (Registered Nurse) #1 concerning the above issues. She stated, "Residents choose not to use masks." "We have to constantly redirect them." "Most of them have dementia, they will take their masks off." *Per CDC Guidance to prevent spread of COVID-19: Actions to take now: Enforce social distancing among residents and ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments. On 6/11/20 at approximately 12:10 PM, an exit interview was conducted with the Administrator, DON and the Infectious Disease Educator. The administrator stated, "We issue masks, especially to our ambulatory residents." "To get some of the ambulatory ones to stay compliant has been a battle." "They keep them under their chins (The masks) or ear." "We redirect them to their rooms."	F 880	care planning, notification of the responsible party and physicians by 6/30/2020. This training will also be included in new hire orientation for all stakeholders. 4. Ongoing audits will be completed by the Director of Nursing, Assistant Director of Nursing, SDC and/or the Unit Coordinators for review of all residents to ensure compliance with wearing face coverings/masks and maintaining social distancing. These audits will be conducted 5 days per week for two weeks, then weekly for two weeks, then monthly for three months. These audits will include documentation of refusals/non compliance of residents wearing face coverings/masks and appropriate care planning . All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or SDC. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Director of Social Services. Other members may be assigned as the need should arise.	