STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted 9/15/2020 through 9/16/2020. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations. The census in this 196 certified bed facility was 120 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted 9/15/2020 through 9/16/2020, and 9/29/2020 through 10/05/2020. Corrections are required for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 196 certified bed facility was 120 at the time of the survey. The survey sample consisted of 26 residents. On 9/30/2020, Immediate Jeopardy was identified in the following area: COVID-19 Testing--Residents & Staff (F886) at a scope and severity level four, pattern. It was removed on 10/05/2020.	F 000		
F 880 SS=E	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	F 880		11/14/20

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

Electronically Signed | 10/26/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 1	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control 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

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F 880	Continued From page 2 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 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 observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain infection control practices and recommendations to prevent the spread of COVID-19 in accordance with The Centers for Medicare and Medicaid Services (CMS), and The Centers for Disease Control and Prevention (CDC) on 2 of 3 floors in the facility. The findings included: The facility staff failed to: (A) properly Don (apply), wear, and Doff (remove), appropriate personal protective equipment (PPE); and	F 880	F 880: Infection control 1. Employee A-no longer works in the facility. Employee B no longer works in the facility. 2. Current residents were considered to be at risk based on the alleged deficient practice. On 10/21/2020, 10/22/2020 and 10/23/2020 the Director of Clinical Services/Nurse Manager began to randomly audit staff using PPE and	

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F 880	Continued From page 3 (B) complete hand hygiene, during the cleaning of Resident rooms. On 9/15/2020 at approximately 10:30 AM Surveyor A met with the facility Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). The facility staff explained the facility layout as follows: 3rd floor is a clean (COVID negative) unit. 2nd floor has 3 halls. One (COVID negative) clean hall, one hall that is 1/2 (new admits on quarantine for 10-14 days) warm, and 1/2 (COVID positive) hot, and 1 full (COVID positive) hot hall. 1st floor consists of 1 (COVID positive) hot hall. Hot is defined by the DON as being Resident's who have COVID-19. The warm unit is Resident's who have been exposed or admitted from a hospital. The clean units are Residents who have tested negative. (A) On 9/15/2020 at 10:57 AM, Surveyor A was waiting for the elevator on the 3rd floor. Surveyor A was touring the facility accompanied by the DON. When the elevator reached the 3rd floor and the door opened an employee (Employee A) exited wearing a faceshield, mask and an isolation gown. Employee A identified himself as being a housekeeper and today being his first day on the job. Employee A reported that he had been on the 2nd floor cleaning a resident room and was coming to the 3rd floor to get another mop head. Employee A was unable to identify the room number of the room he had been working in, on the 2nd floor. The DON stated, "he is part of the housekeeping crew". When asked about wearing PPE in the halls and throughout the facility, the DON stated, "normally we change it when you	F 880	completing handwashing. The audit was completed to ensure that staff are wearing PPE when required and in appropriate areas and that hand washing is completed as needed. Staff observed not donning/doffing or wearing PPE appropriately in addition to not completing hand hygiene appropriately or at the appropriate time were immediately re-educated at the time of the observation. . 3. Staff received education beginning on 10/21/2020 and will be ongoing until current staff has been in-serviced with return demonstration/competency completed. Education includes: hand hygiene, PPE (donning and doffing), infection control and the COVID -19 pandemic plan. Staff members that did not receive education related to the above mentioned will be called and/or sent a certified letter as of 10/27/2020, indicating they may not return to work until the education is received. Newly hired staff will receive education in orientation. 4. Quality Improvement monitoring utilizing a sample size of 10 staff donning/doffing and wearing PPE appropriately, as well as appropriate hand hygiene- to include when and how to perform hand hygiene will be conducted by the Director of Clinical Services/Nurse Manager 3x weekly for 1 month, then 1 x	

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F 880	Continued From page 4 exit a room". (B) On 9/15/2020 at 11:15 AM a housekeeper (Employee B) was observed cleaning in room (Other G) which had signs on the door and doorway to indicate the room was under droplet precautions. The housekeeper was wearing a mask, faceshield, gloves and isolation gown. The housekeeper exited room Other G, still wearing full PPE to include gloves and entered another room (Other H), which had no signage to indicate the Residents in that room were on droplet precautions. Employee B removed the trash and put a new trash bag into the receptacle. Employee B then entered an additional room (Other I), which again had no signage to indicate those Residents were on any precautions. Employee B was interviewed and indicated that she wears PPE to include gloves, gown, mask and faceshield in all rooms and changes gloves between each room. Surveyor A indicated to Employee B that she had been cleaning room Other G, went to rooms Other H, and Other I, and had not doffed her PPE, had failed to change her gloves or performed any hand hygiene. Surveyor A was talking with the DON who was present during the observations, and asked if she had observed any concerns, and the DON said "yes." Employee B then continued on her way, getting ready to enter room Other J, while still wearing the same PPE observed from the beginning of the observations. The DON stopped her and explained she had cleaned a room on droplet precautions, had already entered 2 other rooms not on precautions and was getting ready to enter a third room not on precautions. (Note: The resident in room other G tested negative for COVID19 on 8/31/2020 and 9/10/2020.)	F 880	weekly for 2 months, and then 1 x monthly for 3 months. The Director of Clinical Services/Nurse Manager will report findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 6 months for continued compliance and/or revision to the plan. ADHOC Quality Improvement Performance Committee meeting was held on 10/22/2020 to review the plan set forth to address concerns related to the infection control and PPE issues. The ADHOC QAPI Committee approved the recommendations. 5. Allegation of compliance date: 11/14/2020	

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F 880	Continued From page 5 On 9/15/2020 at 3:35 PM the DON and ADON reviewed the facility floor plan with Surveyor A and identified the 3rd floor as a "clean zone". They identified the 2nd floor hallway consisting of rooms 212-223 as a "clean zone". They also identified that if staff are not in a "hot zone" they expect PPE to be changed between each room and only permit extended use of PPE in the "hot (COVID positive) zone". On 9/15/2020 at 3:54 PM an interview was conducted with the Infection Preventionist (IP). She stated, "staff are permitted to do extended use of PPE only within the hot zone. They are expected to change gloves between each Resident per the health dept, and CDC. We have been sent info on how to use PPE during a PPE shortage. When staff are in cold or warm zones, staff are expected to change PPE, "just like normal, between each room". Review of the facility policy titled "COVID-19 - Pandemic Plan" with a revision date of 9/9/2020 read, "COVID-19 is a respiratory illness thought to be spread mainly from person to person, between people who come in close contact to one another (about 6 feet). The virus is spread through droplets produced when an infected person coughs or sneezes. Symptoms include fever, cough, shortness of breath, sore throat, vomiting, diarrhea, muscle pain, headache, new loss of taste or smell, chills and repeated shaking with chills. 1. Staff will be trained on the facility Pandemic COVID-19 plan and related policies and procedures 2. Staff will be re-trained in Hand Hygiene and proper use of PPE including competency."	F 880		

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F 880	Continued From page 6	F 880		

Review of the facility policy titled "Infection Control" read, "The objectives of our infection control policies and practices are to: a. prevent, detect, investigate, and control infections in the facility; b. maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors and the general public. 4. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control."

CDC guidance stated: "Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices. Hand Hygiene Supplies: Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym). Unless hands are visibly soiled, an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations. Make sure that sinks are well-stocked with soap and paper towels for handwashing. Personal Protective Equipment (PPE): Perform and maintain an inventory of PPE in the facility. Make necessary PPE available in areas where resident care is provided. Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff. Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

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F 880	Continued From page 7 On 9/15/2020 at 4:20 p.m., end of day meeting was held with the Administrator. Findings, facility documents, and observations were reviewed and discussed. The Surveyor advised the Administrator that if he wanted any additional information to be taken into consideration, facility staff would need to provide it. The Administrator verbalized understanding. On 9/16/2020 at 3:15 p.m., and again on 10/5/2020 during an end of day meeting and survey exit the Administrator was again asked if he had any further documentation to provide, and he stated "we have no further information to provide."	F 880		
F 886 SS=K	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or	F 886		11/14/20

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F 886	Continued From page 8	F 886		

suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state
and local health departments to assist in testing

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F 886	Continued From page 9 efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to conduct outbreak testing for 9 of 26 Residents (Residents #2, #7, #8, #9, #10, #11, #12, #24 & #25) and 10 of 14 staff (Employee E, Employee F, LPN C, LPN D, CNA A, CNA C, CNA E, CNA F, CNA G & CNA I). Failure to test during an outbreak reduces the facility's ability to contain the outbreak and increases the likelihood that serious harm, impairment, or death related to COVID-19 will occur. Immediate Jeopardy was identified on 09/30/2020 at 2:30 PM and the facility staff were notified at 4:15 PM. After verification, Immediate Jeopardy was abated on 10/5/2020 at 2:30 PM. The findings included: The facility staff failed to conduct testing of Residents and staff during an active COVID-19 outbreak starting 08/26/2020 and continued through the survey. Note: The regulation "483.80 (h) COVID-19 Testing" did not become effective until 09/02/2020. Non-testing before that date was not included as part of the deficient practice. On 9/15/2020 during a review of the facility employee records the following was revealed: * Employee E had no documentation of testing after 9/02/2020. Review of the testing log, provided by the facility, revealed that Employee E's name was omitted from the testing log.	F 886	F886-COVID-19 Testing-Residents and Staff 1.On 9/29/2020 and 9/30/2020 current residents except those previously tested positive and those that refused and staff (for the exception of 5 who were taken off the schedule) were tested for COVID-19. Agency staff were notified that they were to provide proof of testing within the last 7 days upon reporting to work for their next shift. 2. Current residents were considered to be at risk based on the alleged deficient practice. Testing audits were completed for testing conducted for the week of 10/5 and also the week of 10/12 to ensure that staff were tested as mandated. Staff that did not complete testing was taken off the schedule until their testing was completed. With future testing episodes, the Director of Clinical Services/Nurse Manager will confirm that staff are tested as mandated against the facility employee roster. If resident testing is required, each resident that is tested will be matched against the facility census to ensure compliance with those eligible and consenting to testing	

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F 886	Continued From page 10 *Employee F had no evidence of any COVID testing after 9/02/2020. Review of the testing log, provided by the facility, revealed Employee F's name was omitted from the testing log. *On 9/15/2020 during a facility tour CNA A, told Surveyor A she had not been tested for COVID-19. The facility staff provided no evidence of COVID testing for CNA A after 9/02/2020. On 9/15/2020 at 4:09 PM the facility Human Resources staff indicated she had no additional COVID test results for Employees E, F or CNA A. On 9/15/2020 at 3:54 PM an interview was conducted with the infection preventionist (IP) employee, (Admin employee D). She indicated that the facility is testing staff and Residents weekly. She stated the facility sends a "blast text" to all staff to notify of test dates, if they don't come they call them. She stated that refusals of testing is addressed in their pandemic plan. Surveyor A reviewed the testing log with the IP and both agreed it doesn't indicate weekly testing is being conducted. On the afternoon of 9/15/2020 during an interview with the Corporate Nurse, she indicated the facility had performed testing on 8/27/2020 but the lab specimens were sent to the wrong lab and were not able to be processed. They facility therefore, had to perform retesting on 8/31/2020. The facility staff performed another round of testing on 9/8/2020 and again the lab specimens were sent to the wrong lab and were not able to be processed. The facility staff performed re-testing on 9/10/2020.	F 886	are completed. ED/designee will update testing documentation log with each testing episode. 3. The ED and DCS were educated by the RDCS on 10/20/20 on COVID-19 testing requirements. On 10/21-22/2020 Department heads were educated by the Director of Clinical Services on COVID-19 testing requirements. Staff received education beginning on 10/21/2020 and will be ongoing until current staff has been in-serviced. Education includes: testing requirements including: symptomatic, routine (based on county positivity rates) and outbreak as well as their responsibility to comply with testing episodes. Staff members that did not receive education related to the above mentioned will be called and/or sent a certified letter as of 10/27/2020, indicating they may not return to work until the education is received. Newly hired staff will receive education in orientation.	

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F 886	Continued From page 11 Review of the current Resident listing provided to the survey team on 9/15/2020 by the facility staff, revealed several Residents who were omitted from the testing log. On 9/29/2020 at approximately 1 PM, the facility staff provided the survey team with a testing log, (same log provided on 9/15/2020). They also provided the following logs and data that had not been presented or provided to the survey team on 9/15/2020 - 9/16/2020: * additional testing logs of staff tested on 9/8/2020. * 3 employee lists, each with a separate test date hand written on the top and check marks beside employee names which indicated they were tested for COVID-19 on the test dates written on the forms. * Another Resident log of testing performed from 8/25/2020-9/10/2020 Review of the multiple logs and testing data submitted was reviewed and when compared to the current Resident list and current Employee list revealed the following: * 13 Employees were omitted from the testing log. * The test date of 9/15/20 revealed 51 employee names listed with no indication they were tested. * The employee test date of 9/22/20 revealed 26 employee names without a check mark to indicate they had been tested. * The employee test date of 9/29/20 had 60	F 886	4. Quality Improvement monitoring utilizing a sample size of 15 staff and 15 residents to ensure COVID testing is completed at the center as indicated by the center's outbreak status or indicated by the center's county positivity rate when not in an outbreak will be conducted by the Director of Clinical Services/Nurse Manager 3x weekly for 1 month, then 1 x weekly for 2 months, and then 1 x monthly for 3 months. The Director of Clinical Services/Nurse Manager will report findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 6 months for continued compliance and/or revision to the plan. An ADHOC Quality Improvement Performance Committee meeting was held on 10/22/2020 to review the plan set forth to address concerns related to the infection control and PPE issues. The ADHOC QAPI Committee approved the recommendations. 5. Allegation of compliance date: 11/14/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

(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
F 886	Continued From page 12	F 886		

employee names with no check mark to indicate they had been tested.

* There was no indication of any employee testing being conducted between 09/02/2020 - 9/14/2020.

* There were 11 Residents on the facility census dated 8/27/2020 that were not listed on the testing log.

*There were 9 Residents on the facility census sheet dated 9/29/2020 that were not on the testing log.

On 9/30/2020 COVID test results were requested for a sampling of Residents and Employees. Review of that data revealed the following:

*Resident #2 was admitted on 8/11/2020 and there was no evidence they had ever been tested for COVID-19. Review of the COVID testing log revealed Resident #2 name was omitted from the testing log. Further reviewed revealed Resident #2 refused COVID testing on 8/26/2020 & again on 9/10/2020. However, there was no indication in the clinical record that any attempts were made to test Resident #2 after the 9/10/2020 refusal. Resident #2 was documented as having refused vital signs and nursing assessments often (several times weekly) for COVID monitoring. The resident missed scheduled facility test dates on 9/3/2020, 9/17/2020, and 9/25/2020. There was no documentation that Resident #2 refused testing on those dates.

* Resident #7 was tested 8/27/2020 and again 9/10/2020. The resident missed scheduled the facility test date on 9/3/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 886	Continued From page 13	F 886		

* Resident #8 was tested on 9/10/2020 & again on 9/22/2020. The resident missed scheduled facility test dates on 9/3/2020, 9/17/2020, and 9/25/2020.

* Resident #9 was tested for COVID 9/3/2020, 9/17/2020, 9/25/2020. The resident missed scheduled facility test date on 9/10/2020.

* Resident #10 was tested on 9/10/2020 and 9/17/2020. The resident missed scheduled facility test dates on 9/3/2020 and 9/25/2020.

* Resident #11 was tested on 9/17/2020 and 9/25/2020. The resident missed scheduled facility test dates on 9/3/2020 and 9/10/2020.

* Resident #12 was tested on 9/10/2020, 9/17/2020, and 9/25/2020. The resident missed scheduled facility test date on 9/3/2020.

* Resident #24 missed scheduled facility test dates on 9/3/2020 and 9/10/2020. The resident tested positive for COVID on 9/13/2020 after being sent to the hospital.

* Resident #25 was tested 9/10/2020, 9/17/2020, and 9/25/2020. The resident missed scheduled facility test date on 9/3/2020.

*Employee E had results of a single negative COVID test on 8/27/2020. No other COVID testing was provided for this employee and when records were requested on 9/15/2020 this is the only test result provided. Review of the employee lists provided on 9/29/2020 revealed Employee E was tested on 8/26/2020, 9/15/2020, 9/22/2020, 9/29/2020. There are 13 days between 9/2/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
F 886	Continued From page 14	F 886		

and 9/15/2020.

* Employee F had results of a negative COVID test from a test date of 6/18/2020. The facility provided no further records on 9/15/2020 & 9/16/2020. Review of the employee lists provided on 9/29/2020 revealed Employee F was tested on 8/26/2020, 9/15/2020, 9/22/2020 and 9/29/2020. There are 13 days between 9/2/2020 and 9/15/2020.

* LPN C: the facility provided a copy of a text message with a COVID result of negative from a sample collected on 8/26/2020, 9/3/2020 & 9/20/2020. The document had no identifying information other than a handwritten name of LPN C. There are 17 days between 9/3/2020 and 9/20/2020.

* LPN D: the facility provided no documentation of any COVID testing as requested.

*CNA A: On 9/15/2020 during a facility tour CNA A, told Surveyor A she had not been tested for COVID-19. The facility staff provided no evidence of COVID testing for CNA A.

*CNA C was tested for COVID on 9/22/2020. There are 20 days between 9/2/2020 and 9/22/2020.

*CNA E was tested for COVID on 9/17/2020. The facility staff provided a copy of a text message with a COVID result of negative from a sample collected on 9/25/2020. However, the document had no identifying information other than a handwritten name of CNA E. There are 15 days between 9/2/2020 and 9/17/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

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F 886	Continued From page 15	F 886		

* CNA F: the facility provided no documentation of any COVID testing as requested.

* CNA G: the facility provided no documentation of any COVID testing as requested.

* CNA I: the facility provided no documentation of any COVID testing as requested.

Review of the facility policy titled "COVID-19 Pandemic Plan" with a revision date of 9/9/2020 read, "Outbreak testing: Test all staff and residents in response to an outbreak (defined as any single new infection in staff or any nursing home onset infection in a resident). A resident who is admitted to a center with COVID-19 does not constitute a center outbreak. Continue to test all staff and residents that tested negative every 3 to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result." This policy further read, "Testing Refusal: Staff: Staff who refuses testing during an Outbreak (as defined above), is prohibited from work until the outbreak testing has been completed. Staff who refuses routine testing, will be immediately excluded from work until staff complies with testing requirements."

The Centers for Disease Control and Prevention (CDC) stated: "Testing asymptomatic residents with known or suspected exposure to an individual infected with SARS-CoV-2, including close and expanded contacts (e.g., there is an outbreak in the facility): Perform expanded viral testing of all residents in the nursing home if there is an outbreak in the facility (i.e., a new SARS-CoV-2 infection in any HCP or any nursing home-onset SARS-CoV-2 infection in a resident).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONVIEW REHABILITATION AND HEALTHCARE	7246 FOREST HILL AVE RICHMOND, VA 23225

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F 886	Continued From page 16	F 886		

A single new case of SARS-CoV-2 infection in any HCP [health care personnel] or a nursing home-onset SARS-CoV-2 infection in a resident should be considered an outbreak. When one case is detected in a nursing home, there are often other residents and HCP who are infected with SARS-CoV-2 who can continue to spread the infection, even if they are asymptomatic. Performing viral testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent SARS-CoV-2 transmission." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

The CDC further states: "Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

Immediate Jeopardy was identified on 09/29/2020 at 2:30 PM and the facility staff were notified at 4:15 PM.

The facility presented the following removal plan:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 886	Continued From page 17	F 886		

"F886 Immediate Jeopardy Abatement 9/30/2020
The facility staff failed to conduct required comprehensive COVID-19 testing of both residents and staff members, for a minimum of every 3-7 days, while experiencing an active outbreak of COVID-19 within the facility. Upon review of a sample of 25 resident records, 9 residents were found not to have received the required COVID-19 testing during an active outbreak within the facility. Upon review of a sample of 14 staff records, 10 staff members were found not to have received the required COVID-19 testing during an active outbreak with the facility.

1. Testing of residents occurred on 9/29/20 and 9/30/20. All current resident with the exception of positive residents and the one resident who refused have been tested (including 8 of the 9 identified and COVID testing results are pending. The one resident who continues to exercise her choice to refuse and has been quarantined. As of 9/30/2020 at 10pm, 5 of 10 staff members have received COVID testing while the remaining 5 of 10 staff members have been notified that they have been removed from the schedule until they are able to be tested and or produce negative test results within the last 3 days. Otherwise, these employees will remain out of work while for the duration of outbreak and positivity rate related testing.

2. A) Scheduled weekly outbreak testing of current residents with previous week negative results was completed by a Registered Nurse as of 9/30/20. 1 resident activated her right to refuse testing and was transferred to a room on the designated warm unit and placed on quarantined due to her consistent refusals. She remains

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 886	Continued From page 18	F 886		

asymptomatic at this time but will remain in quarantine until the outbreak has ended. The residents tested were reconciled against the current census to verify all resident have been tested or quarantined.

B) Outbreak testing of current staff members has been completed as of 9/30/2020 at 10pm. Staff tested was reconciled against the staff roster to verify all staff were tested. The staff that were not tested on 9/29 and 9/30/2020 were identified and have been notified that they have been removed from the schedule until they are able to produce a negative COVID test result that coincides with the current test week. Staffing agencies were contacted to inform their staff assigned to the facility to bring test results done within prior 7 days with them when reporting for duty for the 1st time.

3.
A. The Vice President of Operations has educated the Executive Director and Director of Clinical Services on the CMS process on COVID testing as of 9/30/2020 at 430pm to include; Testing of all staff and residents in response to an outbreak-any single new infection in staff or resident. Facility will monitor the county positivity rate every other week and adjust the frequency of performing staff testing accordingly. If the 48 hour turn-around time cannot be met by the processing lab for any reason, the center should have documentation of its efforts to obtain quick turnaround testing results and contact with the local and state health department. Staff experiencing symptoms are expected will be restricted from facility pending results. Residents with signs or symptoms - will be placed on transmission based precautions pending results.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 886	Continued From page 19	F 886		

B. The DCS or designee will make a current list of each resident who should be tested and copies will be distributed to staff to be used to conduct the testing. Once the testing has been conducted the DCS or designee will reconcile the list to verify all residents who require testing have been and follow up to verify residents get tested or staff have documented the refusal and education about testing. DCS or designee will ensure residents who refuse are quarantined until tested or the remainder of the outbreak.

C. The DSC/designee will enter the data on a spreadsheet updating per testing of resident and staff with testing dates and outcomes of testing to maintain documentation of testing.

D. DCS or designee will check agency staff to verify staff scheduled to be at the facility have current testing and those who do not will have rapid POC antigen test performed upon arrival in addition to screening.

4. Ad hoc QAPI was conducted on 10/1/2020 with the IDT to review the outlined planned.

Completion of the above plan will be as of 10/1/2020 at 1pm."

During verification the survey team determined that the last Resident testing for COVID was performed on 10/4/2020 at 5:25 PM, not on the completion date of 10/1/2020 as submitted.

After verification, Immediate Jeopardy was removed on 10/05/2020 at 2:30 PM.