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PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 11/17/2020 through 11/19/2020. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 180 certified bed facility was 152 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control and Abbreviated Survey was conducted onsite 11/17/2020 through 11/19/2020. 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 survey sample consisted of 15 resident and 8 employee reviews. Three complaints were investigated during the survey The census in this 180 certified bed facility was 152 at the time of the survey.	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 comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		12/21/20

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

Electronically Signed | 12/14/2020

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F 880	Continued From page 1 §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 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 2 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, facility documentation review, and clinical record review, the facility staff failed to maintain infection control practices in accordance with the Center for Medicare and Medicaid Services (CMS) and The Centers for Disease Control and Prevention (CDC) recommendations, to prevent the spread of COVID-19 in 1 Resident (Resident #8) in a survey sample of 15 Residents and for facility staff . 1. For Resident #8, the facility staff failed to properly don [put on] PPE (personal protective equipment) while the Resident was on enhanced droplet precautions for COVID-19 and E-Coli (Escherichia coli). 2. The facility staff failed to wear face masks while in the facilty.	F 880	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F880 1. Resident #8 showed no adverse	

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F 880	Continued From page 3 The findings included: 1. For Resident #8, the facility staff failed to properly don [put on] PPE (personal protective equipment) while the Resident was on enhanced droplet precautions for COVID-19. Resident #8 was admitted to the facility on 11/16/2020. Diagnoses for Resident #8 included but were not limited to: wedge compression fracture of second thoracic vertebra, muscle weakness, UTI (urinary tract infection) and E-Coli. On 11/18/2020 at approximatly 10:00 AM, Surveyor A observed CNA A at the bedside of Resident #8. The room door had signage that read, "Enhanced droplet-contact precautions. Perform hand hygiene, surgical mask when entering the room, eye protection when entering the room, gown when entering the room, gloves when entering the room". CNA A was observed with no eye protection on and her isolation gown was falling off of her shoulders because it was not tied around the neck or waist. CNA A was observed to touch Resident #8, and then adjusted her isolation gown and made several attempts to secure it. During this observation of CNA A, CNA B walked over to the bedside of Resident #8, and then proceeded to don (put on) her gloves and isolation gown. CNA B did not put on any eye protection. Once they [CNA A and CNA B] adjusted Resident #8 in the bed, both employees proceeded to the exit door and doffed [removed] their gloves and isolation gowns. CNA B was then observed to have eye goggles hanging from	F 880	effects from the facility staff failing to properly DON PPE. The CNA□s for resident #8 were educated on proper use and the proper method for Donning and Doffing Personal Protective Equipment. The facility staff identified not properly wearing their masks were educated on the importance of, the proper use of and the proper method for Donning and Doffing Personal Protective Equipment to include face masks. 2. All residents are potentially affected. 3. Education has been provided to staff on the importance of, the proper use of and the proper method for Donning and Doffing Personal Protective Equipment to include Face Masks. 4. The DON or Designee will complete 10 observations 3x per week for 2 weeks, then 10 observations weekly x 2 weeks and 10 observations monthly x 1 month on proper use of and Donning and Doffing personal protective equipment to include face masks. Results will be forwarded to QAPI committee for review and recommendations. 5. 12/21/2020	

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her shirt, which she had applied the isolation gown on top of.

Upon CNA A & B's exit from Resident #8's room an interview was conducted. CNA A stated "I am new and still in training". When asked why it is important to wear PPE when caring for Resident #8, CNA A said "let me check and come back". When asked if she was trained in how to properly put on and take off PPE, CNA A stated, "I am still in training".

CNA B was asked what the importance of wearing PPE is. CNA B stated, "to protect yourself". CNA B was asked when you should put on PPE, CNA B stated, "at the door before entering the room". CNA B was told she had been observed at the bedside applying her PPE, CNA B responded "she [CNA A] called me to help and I didn't think about it until I was at the bedside".

On 11/18/2020 an interview was conducted with Employee A, the facility Administrator and Employee B, the director of nursing. Employees A & B stated that PPE is to be doned (put on) at the doorway prior to approaching the bedside. Employee B stated the facility follows CMS guidelines for infection control.

Review of the clinical record for Resident #8 revealed that she had tested negative for COVID-19 on 11/16/2020, the day of admission to the facility.

On 11/19/2020 at 9:30 AM, an interview was conducted with LPN B. LPN B stated, "we only put PPE on if they are on precautions". When asked when PPE should be put on, LPN B stated,

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"before we enter the room". LPN B confirmed it is not appropriate to put PPE at the bedside.

Review of the facility policy titled, "COVID-19" with an effective date of 7/23/2020, read on page b.114, "6. New Admissions/Readmissions: new admissions//readmissions within the fourteen day monitoring period will be cared for using recommended personal protective equipment and placed on Enhanced Droplet-Contact Precaution".

Review of the facility policy titled, "Transmission Based Precautions-General Practice" read, "4. e. The health care team and visitors will be instructed on the importance and necessity of maintaining TBPs [transmission based precautions] before entering the patient's room".

The CDC provides the following guidance: "-Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html

The CDC gives the following guideance to nursing facilities regarding how to don PPE: "How to Put On (Don) PPE Gear. More than one donning method may be acceptable. Training and practice using your healthcare facility ' s

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procedure is critical. Below is one example of donning.
1.Identify and gather the proper PPE to don.
2.Perform hand hygiene using hand sanitizer.
3.Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by other healthcare personnel.
4.Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available).
5.Put on face shield or goggles.
6.Put on gloves.
7.Healthcare personnel may now enter patient room".
Accessed online at:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

The facility Administrator and Director of Nursing were made aware of the findings during an end of day meeting held on 11/18/2020.

No further information was provided.

2. The facility staff failed to wear face masks while in the facility.

On 11/17/2020 at approximately 3:25 PM, Surveyor A approached the main entrance to the facility and found the glass door to be locked. Surveyor A observed 2 signs posted on the front door which read, "STOP! Do Not Enter Without A Face Covering" and "Please Mask-Up Before Entering The Building, Thank You". Surveyor A noted a small table immediately inside the front door which contained a box of facemasks. Surveyor A observed 3 staff members, later

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identified as Employee D-Rehab Manager, Employee E-Occupational Therapy Department, and Employee F-Dietician, standing at the receptionist desk located in the main lobby, having a conversation, all of whom had their facemasks below the level of their chin with exposed mouth and nose. Surveyor A then knocked at the front door to gain entrance and observed the 3 staff members pulling their masks up to cover their mouth and nose. Upon entering the facility, Surveyor A proceeded to the Administrator's office and observed Employee G-Admissions Coordinator exit her office, with no facemask visible, and enter the Administrator's office. Employee G was observed talking with the Administrator for a few minutes and returned to her office without putting on a facemask. The Administrator was observed wearing an appropriate facemask.

On 11/17/2020 at approximately 4:45 PM, an end of day meeting was held with the Administrator (Employee A) and the Director of Nursing (DON, Employee B), both of which stated that all staff members, visitors, and vendors are required to wear a face mask, with mouth and nose covered, before entering the facility and at all times while in the facility except when eating or drinking in a breakroom. A facility policy regarding face masks was requested and received.

On 11/18/2020, review of the facility document entitled, "Infection Prevention & Contol Policies & Procedures, Emerging Infectious Disease(s) (EID), COVID-19", Policy Number 2202 (continued), Effective Date 07/23/20, item 13-a, read, "Prevention measures include, but are not limited to: Universal source control *Employees will wear a facemask while at work, except when

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eating or drinking".

Review of CDC guidance entitled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" updated 11/4/2020, item 1, subtitle "Implement Universal Source Control Measures" read, "Source control refers to use of well-fitting cloth face masks or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-asymptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19" and "HCP [healthcare personnel] should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers...when available, facemasks are preferred over cloth face masks for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others". CDC recommendations/guidelines accessed online 11/18/2020 at:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

The facility Administrator and DON were made aware of the findings during the end of day meeting held on 11/18/2020. No further information was provided.

On 11/19/2020 at approximately 8:50 AM, Surveyor A observed Employee J-therapy

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F 880	Continued From page 9 department enter the facility without a facemask. Employee J put a facemask on after his screening process. The facility Administrator and DON were notified of this finding at the end of day meeting on 11/19/2020.	F 880		
F 886 SS=E	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 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	F 886		12/21/20

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F 886	Continued From page 10 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 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 provide required documentation of COVID-19 testing in 7 out of 7 resident records reviewed. The facility staff failed to document COVID-19 testing in the resident clinical records.	F 886	F886 1. The documentation of COVID-19 testing completed on 11/02/20 through 11/09/2020 for residents #□s 5,7,10,12,13,14 and 15 were uploaded to the residents medical record.	

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F 886	Continued From page 11 The findings included: On 11/17/2020, an interview was conducted with the facility Administrator (Employee A) regarding COVID-19 testing for residents and staff. Facility resident and staff COVID-19 testing logs for November 2020 were requested and received. On 11/18/2020, the facility resident COVID-19 testing logs were reviewed and revealed resident testing had occurred on 11/2/2020, 11/3/2020, and 11/9/2020. Clinical record review was performed for 7 residents (Resident #5, #7, #10, #12, #13, #14, and #15) and revealed no documentation of COVID-19 testing occurrences or testing results within the resident's clinical record. On 11/18/2020, an interview was conducted with both the facility Administrator and the Director of Nursing who also serves as the facility Infection Preventionist (DON-Employee B). When asked about the documentation of COVID-19 testing for residents, the DON stated that information such as test dates and results can be found on the facility resident testing log, however she was not sure if the COVID-19 testing and results were in the individual resident clinical record. The lack of COVID-19 testing documentation in individual clinical records for the 7 sampled residents was discussed and the DON later confirmed that she was unable to locate COVID-19 testing or results in the resident clinical records. No further information was provided.	F 886	2. All resident who have been tested for Covid are at risk 3. SDC or Designee will provide education to Medical records director on the need to upload COVID-19 testing results into the patient medical record. 4. The DON or Designee will conduct an audit of 10% of resident testing results weekly x 2 weeks and monthly x 2 months to ensure proper documentation in the patient medical record. Results will be reviewed in QAPI for review . 5. 12/21/2020	