STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING _____ B. WING _____	C 12/15/2020

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ACCORDIUS HEALTH AT HARRISONBURG LLC	94 SOUTH AVENUE HARRISONBURG, VA 22801

(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 on 12/14/2020. 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 Medicare/Medicaid abbreviated survey and Focused Infection Control survey was conducted 12/14/2020 through 12/15/2020. One complaint was investigated: VA00049305 was substantiated with deficiencies. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements, 42 CFR Part 483.80 infection control regulations, and the CMS and Centers for Disease Control (CDC) recommended practices for COVID -19. The census in this 117 certified bed facility was 72 at the time of the survey. The survey sample consisted of five resident reviews. There were 11 COVID positive residents in the facility. The facility was conducting COVID testing of residents and staff two times per week. The last testing of staff and residents was conducted 12/10/2020.	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.	F 880		

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

Interim - Administrator 12/29/20

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 §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	1. OT #1 and OS #1 were both re-educated on the proper procedure of entering the facility and donning/doffing PPE. 2. All residents and staff have the potential to be affected 3. The facility Policy and Procedures have been reviewed and warrant no change currently. SDC will re-educate staff on the proper hand hygiene procedures for entering the facility and donning/doffing their N95 masks. 4. The DON or designee will audit employees entering the facility at least 2X's a day for 30 days then 1X a day for 60 days to ensure proper hand hygiene prior to Donning N95 masks. Findings will be reported at QAPI meeting for review 5. Date of Compliance: January 5,2021	

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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, and facility document review, the facility staff failed to ensure infection control practices for hand hygiene upon entry to the facility, and prior to donning an N-95 mask, for two of two facility staff. Findings include: On 12/14/20 at approximately 11:25 AM, the front door entrance of the facility was observed for COVID-19 screening and entry procedures. Upon entering the building, immediately to the right was a large table with numerous, small brown paper bags, which contained N-95 masks for each staff member. Just to the left of this table was the receptionist desk area; on top was a large bottle of hand sanitizer and a binder that was opened and documented, "COVID-19	F 880		

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F 880	Continued From page 3 Employee Sign In/Out Log." This log included an area for the date, time, name, department, temperature result, and screening questions for any signs or symptoms of illness for each employee entering and leaving the facility. At approximately 11:30 AM, OT (Occupational Therapist) #1 was observed on the outside of the front entrance to the facility. OT #1 entered a code [for employees only] into a key pad located on the outside of the building with a bare hand. OT #1 then opened the door with a bare hand and entered the facility. Upon entry, OT #1 immediately turned to the right, to the table with the bagged N-95 masks and reached down in to one of the brown paper bags and removed an N-95 mask and donned the mask. OT #1 then turned to the receptionist desk, the receptionist took the OT's temperature and the OT entered the result and completed the form. OT #1 did not use hand sanitizer prior to entry into the facility, the OT did not use hand sanitizer after entry into the facility, and did not use hand sanitizer prior to donning the N-95 mask and reporting to the appropriate department. At approximately 11:35 AM, OS (Other Staff/Head of House Keeping) #1 was observed on the outside of the front entrance to the facility. OS #1 entered a code [for employees only] into a key pad located on the outside of the building with a bare hand. OS #1 then opened the door with a bare hand and entered the facility. Upon entry, OS #1 immediately turned to the right, to the table with the bagged N-95 masks and reached down in to one of the brown paper bags and removed an N-95 mask and donned the mask. OS #1 by-passed the receptionist desk, did not sign in, did not have a temperature check, did not use	F 880		

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F 880	Continued From page 4 hand sanitizer prior to entering the facility, did not use hand sanitizer after entry into the facility, and did not use hand sanitizer prior to donning the N-95 mask and reporting to the appropriate department. At approximately 11:47 AM, the receptionist was interviewed. The receptionist was asked what staff were supposed to to upon entry to the facility. The receptionist stated that they are to enter, get their mask, sign in and get their temperature and then go to work. The receptionist was asked if they were supposed to use hand sanitizer upon entry or upon donning their masks, and if it was the facility's policy to do so. The receptionist stated, "I honestly don't know." At 12:50 PM, the DON (director of nursing) and the administrator were informed of the above observations. The administrator was asked if they used hand sanitizer prior to entry and stated, "We have some out there [outside of the door]." The administrator was made aware that was not observed. The DON stated that they are supposed to get their temperature checked, sign in, change their existing mask to the N-95. The DON stated they need to do something with their hands obviously before they touch anything. The DON asked for a policy on hand hygiene and entry screening procedures. At 1:35 PM, OS #1 was interviewed and made aware that she was not observed using hand sanitizer prior to entering the facility and prior to donning the N-95 mask. OS #1 stated, "Correct." OS #1 was then asked, why? OS #1 stated that she was on break and used it while she was in her car, but did not use it after that [during the	F 880		

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F 880	Continued From page 5 observation period]. OS #1 stated that, she "probably should have" and further stated that she will sometimes use what was outside at the door entrance. At 12:45 PM, OT #1 was interviewed and made aware of the observations of not using hand sanitizer upon entry and prior to donning the N-95 mask. The OT #1 stated, "I didn't use sanitizer, I used it in my car." The OT was asked if he used what was available at the door and OT #1 said he did not. OT #1 was asked if he thought he should use it prior to donning the N-95 mask. OT #1 stated, "Yep." At approximately 3:45 PM, the DON and administrator were again made aware of concerns. The DON presented a policy titled, "COVID 19 VISITATION POLICY", which documented, "...Core Principles of COVID-19 Infection Prevention...screening of all who enter the facility for signs and symptoms of COVID-19...temperature checks, questions or observations about signs and symptoms...b) Hand Hygiene (use of alcohol-based hand rub is preferred)...Appropriate staff use of Personal Protective Equipment..." A COVID -19 response plan was presented which documented, "...Education: ...infection control and prevention training is completed daily by designated department heads..." A policy titled, "Personal Protective Equipment - Using Face Masks" documented, "...to prevent transmission of infectious agents through the air...Put the mask on before entering the room, and after cleaning hands...before changing a face mask, wash hands...Procedure Guidelines:	F 880		

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F 880	Continued From page 6 Putting on the Mask 1. Obtain a mask. 2. Wash your hands. 3. Remove the mask from it's container...Removing the Mask: 1. Wash Hands..." No further information and/or documentation was presented prior to the exit conference on 12/15/20 at 1:15 PM.	F 880		
F 886 SS=D	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	F 886	1. LPN #1 was educated on testing staff and residents utilizing the CDC guidelines/standard of practice on how to conduct an Anterior Swab 2. All residents have the potential To be affected and will be tested utilizing the CDC guidelines of standards of practice on correct procedure of how to conduct Anterior Nasal Swab going forward.	

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F 886	Continued From page 7 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 efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to conduct COVID-19 testing per manufacturer's instructions and/or standards of practice for one of five residents, Resident #6.	F 886	3. The Polices and Procedures for COVID testing were reviewed And no changes were warranted currently. All Nursing staff who perform COVID testing on staff and/or residents will be re-educated by the SDC on Policy and Procedure of the CDC guidelines of conducting all Anterior Nasal Swabs correctly. 4. The DON or designee will audit 2X's per test day for 4 weeks then 1X per test day for 8 weeks to ensure proper Anterior Nasal swabbing technique was used correctly following the CDC guidelines while testing staff and residents. Detailed findings of audit will be reported at QAPI meeting for review. 5. Compliance Date: January 5, 2021	

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F 886	Continued From page 8 Findings include: On 12/14/20 at 12:00 PM, LPN (Licensed Practical Nurse) #1 was observed preparing to administer a nasal swab to Resident #6. LPN #1 obtained the test kit. LPN #1 stated that this kit comes from the lab, which included one individually packaged specimen swab and one small collection tube with a closure top to contain the specimen after collection. The two items were in a small clear plastic bag. LPN #1 stated that she had already labeled the specimen tube with Resident #6's information. No package insert was observed. At approximately 12:10 PM, LPN #1 went to Resident #6 for specimen collection and explained the procedure to the resident. LPN #1 then opened the small plastic bag and retrieved the specimen collection swab, opened the swab and inserted the swab into the resident's right nostril, rotated the swab to the left, to the right, and to the left again and then removed the swab from the resident's nostril (the total time the swab was in the resident's nostril was approximately 6 to 7 seconds). LPN #1 then inserted the swab into the specimen collection container, snapped the swab at the scored mark, closed the specimen container and placed back into the plastic bag. At approximately 12:15 PM, LPN #1 was asked if there was a specific package insert for this kit. LPN #1 stated that "this is how they come from the lab." On 12/14/20 at approximately 1:30 PM, the DON (director of nursing) and the administrator were	F 886		

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F 886	Continued From page 9 asked for a package insert for the test kit/specimen swab used by LPN #1 for when obtaining a COVID-19 specimen from Resident #6, as none was observed and LPN #! could not find one available, when asked. At approximately 2:00 PM, a 40 page package insert was presented, this information was specific to actual test processing after collection. The information documented, "...Specimen collection, Storage, and Handling: Nasal, nasopharyngeal, or oropharyngeal swab specimens should be collected and place in a clean, dry transport tube. Specimens should be transported and tested as soon as possible after collection..." There was no information regarding how to complete the specimen collection process with the swab. A CDC print out was presented by the DON. (1) The DON stated that was what the facility used for the swab specimen that LPN #1 used. The information was from the CDC dated 11/13/2020 and documented, "How to collect your anterior nasal swab sample for COVID-19 testing: Follow the instructions included with your sample kit. Use only materials provided in your kit to collect and store your sample, unless the kit says to do otherwise... 4. Insert the entire absorbent tip of the swab into your nostril, but do not insert the swab more than 3/4 of an inch (1.5 cm) into your nose. 5. Slowly rotate the swab in a circular path against the inside of your nostril at least 4 times for a total of 15 seconds. Be sure to collect any nasal drainage that may be present on the swab. 6. Gently remove the swab. 7. Using the same swab, repeat steps 4-6 in your other nostril. 7. Place swab in tube..."	F 886		

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F 886	Continued From page 10 On 12/14/20 at approximately 3:45 PM the DON (director of nursing) and the administrator were made aware of the above information and made aware of concern regarding the sample collection. On 12/15/20 at a 10:15 AM, LPN #1 was interviewed via phone. LPN #1 stated that she had been trained on specimen collection back in March or April and had not had any training since. LPN #1 stated that she thought that it was a print off, not a video. LPN #1 stated that the kit comes from the lab with one specimen swab and the collection tube and that no package inserts or instructions were included. LPN #1 stated that once the you put the swab in the nostril it should be in there for 15 seconds. LPN #1 was asked if she referenced the procedure prior to administering the swab test to Resident #6. LPN #1 stated, "No, I could go back and look at training if I needed to." No further information and/or documentation was presented prior to the exit conference on 12/15/20 to evidence that the facility staff administered the COVID-19 tests according to manufacturer's instructions and standards of practice. (1) https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/COVID-19-anterior-self-swab-testing-center.pdf https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html: Anterior nasal (nares) specimen (updated 11/30/20): Using a flocked or spun polyester swab, insert the	F 886		

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F 886	Continued From page 11 entire absorbent tip of the swab (usually ½ to ¾ of an inch (1 to 1.5 cm) inside the nostril and firmly sample the nasal wall by rotating the swab in a circular path against the nasal wall at least 4 times. Take approximately 15 seconds to collect the sample. Be sure to collect any nasal drainage that may be present on the swab. Sample both nostrils with same swab. For a visual guide, see the How To Collect Your Anterior Nasal Swab Sample For Covid-19 Testing infographic.pdf icon	F 886		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and during the course of a complaint investigation, the facility staff failed to ensure a functions, and sanitary environment in the kitchen. The facility staff failed to repair an identified structural concern to prevent pests entry into the facility. Findings include: On 12/14/20 the facility's pest logs were requested for May, June and July 2020. A pest control report dated 06/20/20 documented, "...Pest Activity found during service: Kitchen area - interior small flies notes during service...Structural concerns that could cause pest problems: rear-door introduction point --exit	F 921		

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F 921	Continued From page 12 door doesn't close/seal properly - 1/4 inch gap or greater exists. Install/replace door sweep. Install weather stripping. measures here will reduce the number of pests entering the area..." A pest control report dated 07/14/20 documented, "...Structural concerns that could cause pest problems: Rear door - Introduction Point--exit door doesn't close/seal properly -1/4 inch gap or greater exists. Install/replace door sweep. Install weather stripping...measures here will reduce the number of pests entering the area..." A pest control report dated 08/18/20 documented, "...Structural concerns that could cause pest problems: Rear door - Introduction Point--exit door doesn't close/seal properly -1/4 inch gap or greater exists. Install/replace door sweep. Install weather stripping...measures here will reduce the number of pests entering the area..." A pest control report dated 09/30/20 documented, "...Structural concerns that could cause pest problems: Rear door - Introduction Point--exit door doesn't close/seal properly -1/4 inch gap or greater exists. Install/replace door sweep. Install weather stripping...measures here will reduce the number of pests entering the area..." A pest control report dated 09/30/20 documented, "...Structural concerns that could cause pest problems: Rear door - Introduction Point--exit door doesn't close/seal properly -1/4 inch gap or greater exists. Install/replace door sweep. Install weather stripping...measures here will reduce the number of pests entering the area..." A pest control report dated 11/25/20 documented, "...Structural concerns that could cause pest	F 921	1. Rear -door Introduction Point at Exit Door located in kitchen area was fixed. The improper seal and closure were repaired. 2. Exit doors in the facility were inspected to assure they were in good repair and had proper Seal and closure. 3. Education was given to Maintenance Director regarding Exit doors to assure they are maintained to include proper repair, seal and closure. Maintenance Director educated on communication between facility and vendor upon completion of task/job.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING _____ B. WING _____	C 12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HARRISONBURG LLC	94 SOUTH AVENUE HARRISONBURG, VA 22801

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F 921	Continued From page 13 problems: Rear door - Introduction Point--exit door doesn't close/seal properly -1/4 inch gap or greater exists. Install/replace door sweep. Install weather stripping...measures here will reduce the number of pests entering the area..." On 12/14/20 at 12:50 PM, the entry/exit door located in the kitchen area described above was observed. Upon observation the assistant maintenance director had the door open and had a drill with a wire brush on the end of it, running it along the inside of the door frame. The assistant maintenance director was asked what he was doing. He stated that he was knocking off dirt and dust. The maintenance director then came into the kitchen and was asked to shut the door. The door was shut for inspection. While the door was shut, upon grasping the door knob and pulling or pushing, the door had a gap [approximately 1/4 inch or more], which exposed daylight and significant air flow. The door was operational, but was in ill repair and did not have a proper seal and closure. There was a metal strip located on the outside of the door, at the bottom of the door. There was no door sweep observed on the door interior and no weather stripping was present on any portion of the door or frame, as recommended by the pest control company. The maintenance director stated that the metal strip on the outside had just been replaced, but was not sure who replaced it or when it was replaced. There were no records of this to evidence replacement. On 12/14/20 the maintenance director, DON (director of nursing) and the administrator were ...	F 921	4. Proper maintenance of Exit doors and F/U communication between facility and vendors will be monitored by Administrator or Designee 3X weekly for 4 weeks then 1X weekly for 4 weeks then 1X monthly for 4 months. Findings will be reported in QAPI meeting for review. 5. Date of Compliance January 5, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING _____ B. WING _____	C 12/15/2020

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F 921	Continued From page 14 made aware of the above findings and concerns. No further information and/or documentation was presented prior to the exit conference on 12/14/20. This is a complaint deficiency.	F 921		