STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. BUILDING _____ B. WING _____	10/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNCHBURG HLTH & REHAB CNTR	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey and Focused Infection Control survey was conducted on 10/20/2020 through 10/21/2020. Three complaints were investigated during the survey. VA00049729 was unsubstantiated with related deficient practice. VA00048257 was unsubstantiated with no deficient practice. VA00047864 was substantiated with no deficient practice. Corrections are required with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 148 at the time of the survey. The survey sample consisted of 5 current record reviews and one closed record review. There were no COVID-19 positive cases in the facility at the time of the survey. The last facility wide testing was completed on 10/13/2020 that included 139 residents, all testing negative, and 131 staff, all testing negative. On 10/20/2020, the facility tested 41 residents on the South wing with pending results. The reminder of the facility's residents and staff were scheduled for testing on 10/21/2020.	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 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		11/10/20

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

Electronically Signed | 11/07/2020

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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 observation, staff interview, and facility document review, facility staff failed to follow infection control guidelines for 14 of 29 resident rooms on the skilled unit. Fourteen rooms housing residents under observation for potential COVID-19, did not have droplet precaution signage per Centers for Disease Control (CDC) guidance. Findings included: Upon arrival to the facility on 10/20/2020 at 10:00 a.m. an initial meeting was held with the Administrator and DON (director of nursing). During this meeting the Administrator and DON were interviewed regarding the location of the current COVID-19 unit. Both the Administrator and the DON stated the skilled unit is the current "warm unit," but "we do not have any COVID positive patients at this time." The DON was interviewed regarding how many residents were	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. No residents affected by the deficient practice were positive for Covid. The 14 affected resident rooms have had	

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F 880	Continued From page 3 currently under observation for potential COVID-19. The DON stated, "You mean new admits under prophylactic quarantine? I think around 12." A walk through of the skilled unit was conducted at approximately 11:00 a.m. The skilled unit included 29 rooms. Fourteen rooms, occupied with 21 residents, were identified as being on "Enhanced Precautions", Donning and Doffing PPE (personal protective equipment), and had a PPE caddy hanging on the outside of the room door. No signage specific to droplet precautions was observed on any of the 14 isolation doors. Infection Control, COVID-19 specific, and Isolation policies were requested from the DON on 10/20/2020 at 12:00 p.m. Policies received included: "Infection Outbreak Standards of Practice, Effective 02/06/20, Enhanced Barrier Precautions (EBP's), Effective 09/26/19, Transmission Based Precautions (TBP's)-General Practice, Effective 02/06/20, and Transmission Based Precautions, Effective 02/06/20." The EBP policy included, "Employees providing high-contact patient care activities will follow Enhanced Barrier Precautions (EBPs). This level of precaution is indicated during the implementation of a containment strategy to prevent potential transfer of a novel or targeted multi-drug resistant organism (MDRO). Enhanced Barrier Precautions falls between Standard and Transmission-based Precautions and refers to the use of gown and gloves during high-contact patient care activities...EBPs does not replace existing guidance regarding the use of Transmission-based Precautions for other	F 880	enhanced droplet precaution signs placed on the door of each room to ensure that staff entering know what PPE is required upon entering. 2. A hot unit (rooms with enhanced droplet precautions for COVID positive residents) was set up to differentiate from the warm unit (rooms with enhanced droplet precautions for residents suspected to have COVID and new admissions). All warm unit rooms were placed on enhanced droplet precautions. The floor plan was reviewed to establish a plan to clearly identify the hot and warm units. Empty rooms were utilized to separate the hot and warm units and a plastic barrier was placed between the hot and warm units. As patients come off isolation, they are transferred to a cold unit (unit without enhanced droplet precautions). All admissions are placed on enhanced droplet precautions and placed on the warm unit for 14 days. They are not cohorted with patients who have been exposed to COVID. The 14 affected resident rooms have had enhanced droplet precaution signs placed on the door of each room to ensure that staff entering know what PPE is required upon entering. 3. Daily observation, reporting of isolation patient status, patients cleared and moved to a cold unit are reviewed by the Administrator, DON or designee and Admissions Director/Coordinator or designee daily. 4. Admission verification and room assignments are monitored by the SDC or designee and the DON or designee daily.	

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F 880	Continued From page 4 pathogens..." TBPs policy included, "The Center initiates transmission based precautions (to include droplet and contact precautions) as recommended by the Center for Disease Control (CDC)...they are used in addition to standard precautions...Droplet Precautions...use droplet precautions, for a patient known or suspected to be infected with microorganisms transmitted by droplets..." CDC guidance for posting signage states, "When implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves)..." (1) CDC guidance dated June 25, 2020, "Preparing for COVID-19 in Nursing Homes...Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown... HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents..." (3) The Administrator was interviewed at approximately 4:00 p.m. The Administrator stated, "New admissions or readmissions have always gone on the skilled unit for the 14-day quarantine." Regarding placement of known	F 880	All deviations in procedure will be reported to the Administrator and submitted to the QAPI committee for evaluation and recommendations. 5. Date of Compliance 11/10/2020	

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positive COVID residents the Administrator stated, "The back hall of the South Unit would be the "Hot Hall." Those rooms were identified as rooms 78 through 87.

CDC guidance dated April 30, 2020, "Responding to Coronavirus (COVID-19) in Nursing Homes...Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms..." (2)

The Administrative team was informed of the above findings during a meeting with the survey team on 10/21/2020 at approximately 12:25 p.m.

(1) CDC (Centers for Disease Control and Prevention), July 26, 2019, Implementation of Personal Protective Equipment (PPE) in Nursing Homes to Prevent Spread of Novel or Targeted Multidrug-resistant Organisms (MDROs), accessed October 22, 2020, <https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html>

(2) CDC, April 30, 2020, Responding to Coronavirus (COVID-19) in Nursing Homes, Page 2, accessed October 22, 2020, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html>.

(3) CDC (Centers for Disease Control and Prevention), June 25, 2020, Preparing for COVID-19 in Nursing Homes, Page 6, accessed October 22, 2020,

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F 880	Continued From page 6 <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>.	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 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;	F 886		11/10/20

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F 886	Continued From page 7 §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, facility staff failed to conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests for one of six residents in the survey sample, Resident #5. Findings included: Resident #5 was admitted to the facility on 09/18/2020 with diagnoses including, but not	F 886	F886 1. The resident was retested using the proper procedure per manufactures guidelines. The patient was found to be negative. 2. All patients were at risk to have sample collected incorrectly. Education of all nursing staff has been completed to prevent errors in collection. 3. The nursing staff will be reeducated to	

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F 886	Continued From page 8 limited to: ORIF (open Reduction Internal Fixation) Left Femur Fracture, Compression Fracture Thoracic Vertebra, Left Rib Fracture, Left Radius Fracture, and ESRD (end stage renal disease) requiring Hemodialysis. The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 09/24/2020. Resident #5 was assessed as cognitively intact with a total cognitive score of 15 out of 15. On 10/20/2020 at 11:32 a.m. RN #1 (registered nurse) was observed administering a COVID-19 test to Resident #5. RN #1 donned appropriate PPE (personal protective equipment), explained the procedure to Resident #5, and performed the COVID-19 test. RN #1 swabbed both nostrils, placing the testing swab approximately one inch into each nostril, then placed the swab into sterile container and plastic lab bag. RN #1 was then interviewed regarding testing procedure. RN #1 stated, "You only have to go up each nostril about one inch. I swab both nostrils to make sure nasal membranes are swabbed adequately." RN #1 provided the packaging insert, including test administration instructions, from the actual COVID-19 test used. The COVID-19 test package insert included, "Product Specifications...Nasopharyngeal Specimen Collection Swab: ...Gently insert swab into the nostril along the septum floor of the nose extending straight back until the posterior nasopharynx is reached (distance from nostrils to external opening of ear). Rotate the swab several times while the swab is in contact with the	F 886	reinforce manufactures guidelines and ensure that they are followed. 4. Nursing staff will be randomly observed collecting specimens to ensure compliance. Results of observations will be reported to the Administrator and provided to the QAPI committee for evaluation and recommendations. 5. Date of Compliance 11/10/2020	

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F 886	Continued From page 9	F 886		

nasopharyngeal wall..." RN #1 stated, "This is a mail away test. We do not use rapid tests on patients."

The package insert was reviewed with RN #1. At approximately 12:00 p.m., RN #1 stated regarding the specimen collection technique used during the COVID-19 testing of Resident #5, "I told you the information for the other test, POC test [rapid test]. That test you only insert the swab into the nares about one inch. (Name) Resident #5's test is invalid. I will redo her test when she returns from dialysis this evening."

The above observations were discussed with the Administrative team during a meeting with the survey team on 10/21/2020 at approximately 12:25 p.m.