STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING _____ B. WING _____	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT LYNCHBURG LLC	2081 LANGHORNE ROAD LYNCHBURG, VA 24501

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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted from 10/08/2020 through 10/09/2020. 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 onsite Focused Infection Control survey was conducted from 10/08/2020 through 10/09/2020. Corrections are required for the facility to be in compliance with 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 120 certified bed facility was 87 at the time of the survey. There were no positive COVID cases in the facility. The survey sample consisted of five resident reviews.	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 program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880	The facility has established an infection prevention and control program.	

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

Administrator 10/28/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1	F 880		

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 contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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F 880	Continued From page 2 §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 document review and clinical record review, the facility staff failed to follow infection control practices for four of five residents in the survey sample, and failed to implement infection prevention protocols during environmental cleaning. 1. Facility staff failed follow infection control protocols when Resident #2 was assessed with a fever. 2. Resident #4, on droplet/contact precautions due to COVID-19 protocols after a readmission, was out of his room, without use of a face mask/covering and not practicing cough etiquette/hygiene. No attempts were made by staff to redirect to the resident to his room or encourage use of a face covering/tissue. 3. Facility staff failed to follow infection control policy for disinfection of medical equipment after use with Resident #5 who was on droplet/contact precautions on the COVID-19 quarantine unit.	F 880	Resident #2 was administered Tylenol 325 mg twice. The resident was PCR tested and she tested negative. Resident #4 had a sitter put in place. This resident was PCR tested and the results came back negative.This resident was also POC tested on 10/08/20. The DON and SDC met with the specific nurse who did not intervene. Resident #5 was observed and developed no signs of infection.The Director of Rehab inervenened and informed the LPTA to use Micro-Kill wipes on the equipment.	11-02-20

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F 880	Continued From page 3 4. No sign was posted on Resident #1's room/door indicating physician ordered contact precautions due to a diagnosed infection. 5. Three resident rooms on the COVID-19 quarantine unit had no signs displayed indicating the requirement for droplet/contact precautions. 6. Housekeeping staff failed to apply required personal protective equipment (PPE) during cleaning. A housekeeper moved all of Resident #2's personal belongings/furniture into the hallway on the designated COVID-19 quarantine unit while the resident was identified with contact/droplet precautions. The findings include: 1. Resident #2 was admitted to the facility on 3/3/20 with a readmission on 9/17/20. Diagnoses for Resident #2 included end stage renal disease with hemodialysis, diabetes, atrial fibrillation, sepsis, dementia, hypertension and insomnia. The minimum data set (MDS) dated 9/1/20 assessed Resident #2 with severely impaired cognitive skills. Resident #2's clinical record documented daily temperature checks as part of the facility's monitoring for symptoms of COVID-19. On 10/7/20 at 10:08 p.m., Resident #2 was assessed with a temperature of 100.2 degrees (F). A nursing note dated 10/7/20 at 10:08 p.m. documented, "Tylenol Tablet 325 MG [milligrams] Give 2 tablets...Pts [patient's] fever is 100.2. Administering [Tylenol] to see if it will help..." A nursing note dated 10/7/20 at 11:21 p.m. listed	F 880	Resident #2 was administered Tylenol 325 mg twice. The resident was PCR tested and the results came back negative. Since all other residents have the potential to be affected by an elevated temperature. The temperature will be rechecked. If the resident's temperature is found to still be elevated the nurse will notify the doctor. The nurses and CNA will be in-serviced to re-check the elevated temperature. If the resident's temperature is found to still be elevated the Nurses will be in-serviced on following the action plan that includes notifying the doctor. The resident's temperature will be treated per the doctor's orders. The nurses will be in-serviced to complete a Respiratory Assessment on a resident with an elevated temperature. All vital signs (VS) will be recorded on the the "Vital Sign Log" and it will be monitored by the DON/or his designee weekly and by the weekend Supervisor or her designee will oversee the log for elevated temps over weekend.	11-02-20

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F 880	Continued From page 4 the Tylenol was "ineffective" and documented, "PT [patient] started with a fever of 100.2 and when last checked it was 100.5." The record documented no notification to the physician or infection preventionist regarding the resident's fever and no additional resident assessment at the time of the elevated temperatures. On 10/8/20 at 10:30 a.m., the registered nurse (RN #2) caring for Resident #2 was interviewed about the resident's fever assessed on 10/7/20. RN #2 stated Resident #2 was on the quarantine unit because she went out of the facility routinely to dialysis. RN #2 stated Resident #2 had increased temperatures when she turned up the heat in her room. RN #2 stated when the resident's room temperature was turned down, the resident's fever went away. When asked about the situation on 10/7/20, RN #2 stated he was not sure about why she had a fever because he was not working that day. On 10/8/20 at 10:40 a.m., the director of nursing (DON) was interviewed about temperature checks. The DON stated nurses were checking all resident temperatures each shift to monitor for signs of possible COVID-19. The DON stated there was an action plan for temperatures above 99.0 degrees. On 10/9/20 at 10:00 a.m., the registered nurse infection preventionist (RN #1) was interviewed about Resident #2's fever. RN #1 stated she was not aware Resident #2 had a fever on 10/7/20. After reviewing the clinical record, RN #1 stated the nurse administered Tylenol for the fever of 100.2 and then rechecked the resident's temperature with the second reading still elevated at 100.5 degrees. RN #1 stated nursing should	F 880	These findings will be reported to the DON or his designee if the resident is symptomatic and if the doctor orders the resident to be POC tested. Findings will be reviewed weekly at the Risk meeting and reported Monthly at the QA meeting.	

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have notified the DON and her for follow up and performed further assessment of the resident. RN #1 stated the facility had a fever care protocol that required additional assessments for temperatures greater than 99 degrees (F). RN #1 stated the additional assessments of Resident #2 were not performed on 10/7/20 when the elevated temperatures were assessed.

The facility's COVID-19 Plan (revised September 2020) documented concerning preventive actions for COVID-19, "...All residents in center receiving Q [each] shift temperature monitoring. Exceeding 99.0 requires action..."

The facility's Care Path for Fever (revised June 2018) defined fever as one temperature greater than 100 degrees (F) or two temperatures greater than 99 degrees (F). This protocol documented if a resident was assessed with a fever, vital signs were supposed to be checked that included blood pressure (apical heart rate if pulse irregular), respiration rate, oxygen saturation and finger-stick glucose check for diabetics. If any of the following criteria were met, the protocol required nursing to notify the physician/provider: temperature > than 100.5; apical heart rate >100 or <50; respiratory rate >28/minute or <10/minute; systolic blood pressure <90 or >200, oxygen saturation <90%; finger-stick glucose <70 or >300; or resident unable to eat or drink. If the vital signs were out of listed ranges, the protocol required nursing to evaluate the resident for other sources of fever (cough, lung sounds, appetite, mental status change, abdominal distention, low urine output, new skin condition, increased pain or signs/symptoms of sepsis). The protocol required notification to the physician of the expanded assessments to determine possible

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F 880	Continued From page 6 source of the fever. These findings were reviewed with the administrator, director of nursing and infection preventionist on 10/8/20 at 1:45 p.m. and on 10/9/20 at 11:45 a.m. 2. Resident #4 was admitted to the facility on 4/4/19 with diagnoses that included history of traumatic brain injury, metabolic encephalopathy, hemiplegia, dysphagia, pneumonitis from aspiration, schizoaffective disorder, anxiety, hypertension, moderate intellectual disabilities, depression, dementia with behavioral disturbance and urinary tract infection. The minimum data set (MDS) dated 7/7/20 assessed Resident #4 with severely impaired cognitive skills. On 10/8/20 at 10:15 a.m., the designated quarantine unit for new admissions/readmissions was inspected. Resident #4 was observed at this time in the hallway near the nursing station. The resident was seated in a wheelchair, had a mask positioned on his neck with no covering over his mouth or nose. Resident #4 coughed multiple times with no covering of his mouth or attempted cough etiquette. Another masked resident (Resident #2) was seated in a wheelchair on the same side of the hallway approximately 10 to 12 feet from Resident #4. A staff member was observed across the hall from the resident standing at the medication cart. On 10/8/20 at 10:30 a.m., the registered nurse (RN #2) caring for Resident #4 was interviewed. RN #2 stated the resident was on quarantine for 14 days because he had been out of the facility recently for treatment. RN #2 stated Resident #4 would not stay in his room and refused to wear a	F 880	Resident #4 had a sitter put in place. This resident was previously PCR tested and his results negative. Because of his coughing, he was POC tested on and he tested negative. This resident has impaired cognition and a BIM's Score of zero. The DON and SDC met with the specific nurse who did not intervene on behalf of the resident. This resident will be encouraged on a daily basis to wear his mask when in the hallway or will be redirected to his room. We will identify all other residents that have the potential to be affected by the deficient practice. All identified residents will have their care plans updated. The staff have been in-serviced on droplet/ contact precautions due to COVID-19 when a resident is out of his/her room. The staff have been informed to intervene and attempt to have the resident wear a mask/ covering and practice cough etiquette/ hygiene. They have also been informed to offer the resident a face/covering/ tissue and/or redirect the resident to his/her room. We have shared the CDC "How to Protect Yourself" handout and shared the "How to Protect Yourself" U-Tube Video. The Administrator met with the residents and reviewed the survey findings, demonstrated wearing a mask,why wearing a mask is important and reviewed cough etiquette as depicted in the CDC handout.	11-02-20

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F 880	Continued From page 7 mask. RN #2 stated Resident #4 "was violent" and hit staff members attempting care. RN #2 stated staff were unable to redirect the resident, as he was frequently aggressive. When asked how they were maintaining droplet precautions when the resident was in the hall and not wearing a mask or face covering, RN #2 stated he was not sure. Resident #4, across the hall from RN #2 at the medication cart, coughed multiple times without covering his mouth during the interview with RN #2. RN #2 did not attempt to redirect the resident to his room, encourage a face covering, or provide a tissue for coughing. On 10/8/20 at 10:55 a.m., Resident #4 was observed again in his wheelchair in the hallway near the nursing station. The resident had no covering in place over his mouth/nose. RN #2 and several other staff members were observed going up/down the hallway. No staff members attempted to redirect Resident #4 to his room or encourage him to wear a mask. On 10/8/20 at 11:00 a.m., the infection preventionist (RN #1) was interviewed about Resident #4 in the hallway on the quarantine unit without a face covering. RN #1 stated Resident #4 was "challenging" and did not like to stay in his room. When asked what interventions were implemented to maintain droplet/contact precautions on the unit, RN #1 stated the resident was redirected to his room. On 10/8/20 at 1:15 p.m., the administrator and director of nursing (DON) were interviewed about Resident #4. The administrator stated all residents on the quarantine unit were on droplet/contact precautions as part of their COVID-19 action plan with the exception of two	F 880	All staff will be randomly remind residents as applicable to wear a mask when they are out of their room and to use cough/sneeze/ hygeine ettiquette. We will review and monitor residents who are not wearing masks daily and remind them to do so. The residents will be reminded to use cough etiquette as applicable.	11-02-20

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residents (one for C-diff infection, one on dialysis). The DON stated Resident #4 was sent to the emergency room on 10/4/20 due to aggressive behaviors and was diagnosed with a urinary tract infection. The DON stated Resident #4 had been on the quarantine since 10/4/20 when he returned from the emergency room. When asked what interventions were used to maintain droplet/contact precautions with Resident #4, the DON stated, "It's a challenge." The DON stated the resident refused to wear a mask, would not stay in his room and had intellectual disabilities. The DON stated staff attempted redirection with Resident #4 but it was not effective.

Resident #4's clinical record documented agitation and physical hitting toward staff. A nursing note dated 10/3/20 at 4:01 p.m. documented, "Patient noted up in wheel chair casing [chasing] staff and hitting and kicking at staff..." A nursing note dated 10/4/20 documented, "Resident was showing extreme agitation and attempting physical assaults on staff...Police and EMS was called...resident angry, confused, aggressive towards staff, hitting, kicking, spitting, attempting out of his chair. Unable to calm resident, for resident safety, emergency services call. On call MD [physician] was called...Resident remains combative. Unable to calm resident...Resident was transferred to hospital for observation at this time..." (Sic)

The clinical record documented the resident returned to quarantine unit of the facility on 10/4/20 at 1:13 p.m. with droplet/contact precautions in place. A nursing note dated 10/4/20 at 2:38 p.m. documented, "Resident

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screaming in hallway, cursing at staff..."

Resident #4's plan of care (updated 10/8/20) documented the resident had behaviors of "loudly yelling out repetitive phrases r/t [due to] intellectual disabilities...also non-compliant with wearing a mask outside of room and refuses to despite encouragement." Interventions to minimize yelling out included, "Administer medications as ordered...Anticipate and meet The resident's needs...Encourage the resident to express feelings...Caregivers to provided [provide] opportunity for positive interaction...Stop and talk with him/her as passing by...Educate on reason, continue to encourage and assist [Resident #4] to wear face mask when out of room...Minimize potential for the resident's disruptive behaviors...Praise any indication of The resident's progress...Provide a program of activities..." (sic)

The facility's policy titled Isolation - Categories of Transmission-Based Precautions (revised January 2012) documented concerning droplet precautions, "...In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganism transmitted by droplets (large-particle droplets...that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning...Limit movement of resident from the room to essential purposes only...If transport or movement from the room is necessary, place a mask on the infected individual and encourage the resident to follow respiratory hygiene/cough etiquette to minimize dispersal of droplets..."

These findings were reviewed with the

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F 880	Continued From page 10 administrator, DON and infection preventionist on 10/8/20 at 1:45 p.m. and on 10/9/20 at 11:45 a.m. 3. Resident #5 was admitted to the facility on 3/18/19 with diagnoses that included COPD (chronic obstructive pulmonary disease), diabetes, coronary artery disease, heart failure, renal insufficiency, anxiety and depression. The minimum data set (MDS) dated 9/1/20 assessed Resident #5 as cognitively intact. On 10/8/20 at 11:05 a.m., a licensed physical therapy assistant (LPTA - other staff #1) was observed taking a blood pressure machine/cuff and a pulse oximeter for measuring oxygen saturation levels into Resident #5's room. Resident #5 was on droplet/contact precautions for 14 days following an admission/readmission to the facility. The LPTA, dressed in full personal protective equipment (PPE) (face shield, gloves, gown, N95 mask), placed the blood pressure cuff on the resident's arm and the oximeter sensor on the resident's finger. After completing the measurements, the LPTA removed the PPE, washed her hands and took the blood pressure device and oximeter to the therapy room. On 10/8/20 at 11:09 a.m., the LPTA got a washcloth and quickly wiped the blood pressure cuff, blood pressure display box and the pulse oximeter device. The LPTA was interviewed at this time about cleaning/disinfecting of the equipment. The LPTA stated she was using diluted Mr. Clean disinfectant to clean and sanitize the equipment. When asked what the contact time was for Mr. Clean, the LPTA stated it did not have a contact time. The LPTA presented the bottle of Mr. Clean used to disinfect the equipment. This product was labeled Mr. Clean	F 880	Resident #5 was observed and developed no signs of infection.The Director of Rehab intervenened and informed the LPTA to use Micro-Kill wipes on the equipment. This resident was receiving Therapy services.The Therapy Director intervened on behalf of the LPTA to use the Mirco- Kill wipes. Since all other residents have the potential to be affected by the deficient practice staff will be informed about using designated disinfectant wipes. The Therapy staff were in-serviced on the importance of using the facility designated disinfectant wipes to clean any equipment that they use for a resident. Our other staff will be in-serviced on the importance of using the facility designated disinfectant wipes. This process will be randomly audited by the Administrator or her designee three times a week times four weeks and then randomly thereafter. This will be reported at the Monthly QA meeting.	11-02-20

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antibacterial cleaner - Summer Citrus. The LPTA stated she used the blood pressure machine/cuff and oximeter with her therapy residents throughout the facility.

On 10/8/20 at 11:12 a.m., the rehab director (other staff #2) joined the interview with the LPTA. The rehab director was interviewed about the use of Mr. Clean to sanitize resident use equipment. The rehab director read the manufacturer's label on the Mr. Clean and stated it required a 10-minute contact to kill germs. The rehab director stated at this time that therapy staff were supposed to be using Microkill wipes to disinfect therapy and medical devices used with residents. The rehab director had a new container of Microkill wipes and stated the contact time printed on the Microkill label was 30 seconds. The rehab director stated she just got a supply of Microkill wipes that morning (10/8/20) and was using the Mr. Clean as a back up.

On 10/8/20 at 1:15 p.m., the administrator and infection preventionist (RN #1) were interviewed about the Mr. Clean used by therapy staff on resident equipment. The administrator and RN #1 stated the Mr. Clean was not purchased by the facility and they did not know where the therapy staff got the Mr. Clean. When asked for the Mr. Clean material safety data sheet, RN #1 stated they did not have one as the product was not purchased or provided by the facility. The administrator stated there was no shortage of Microkill wipes or other commercial products for sanitizing equipment and surfaces. The administrator stated inventory of Microkill wipes was adequate and therapy staff only had to requisition to get the needed wipes.

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F 880	Continued From page 12 The facility's policy titled Cleaning and Disinfection of Resident-Care Items and Equipment (revised July 2014) documented, "Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard....Non-critical items are those that come in contact with intact skin but not mucous membranes...Reusable items are cleaned and disinfected or sterilized between residents...Intermediate and low-level disinfectants for non-critical items include...Ethyl or isopropyl alcohol...Sodium hypochlorite...Phenolic germicidal detergents...Iodophor germicidal detergents...and Quaternary ammonium germicidal detergents..." These findings were reviewed with the administrator, director of nursing and infection preventionist on 10/8/20 at 1:45 p.m. and on 10/9/20 at 11:45 a.m. 4. Resident #1 was admitted to the facility on 1/6/20 with diagnoses that included ESBL (extended-spectrum beta-lactamase) urinary infection, hypothyroidism, acute kidney failure, hypertension, dysphagia, bipolar disorder, anxiety and anorexia. The minimum data set (MDS) dated 9/8/20 assessed Resident #1 with moderately impaired cognitive skills. On 10/8/20 at 10:00 a.m., a supply cart was observed beside the doorway to Resident #1's room. There was no sign on the door or wall near the room entrance indicating any type of required infection precautions or PPE required. Resident #1's clinical record documented a	F 880	Resident #1 was transferred to the room on 10- 6 -20. The sign not being placed on the door was an oversight. This was corrected.	

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F 880	Continued From page 13 physician's order dated 10/7/20 for "contact isolation" due to ESBL infection. On 10/8/20 at 10:10 a.m., the licensed practical nurse (LPN #1) caring for Resident #1 was interviewed about the cart and no signage at the room. LPN #1 stated Resident #1 was on contact precautions due to a urine infection. LPN #1 stated staff were supposed to wear gown, gloves and a mask when entering the room due to the precautions. When asked about why there was no sign indicating the need for precautions and PPE, LPN #1 stated the resident had recently moved from another unit and the infection control signs had not been posted. LPN #1 stated the resident had been on the new unit a day or two. On 10/8/20 at 1:15 p.m., the registered nurse infection preventionist (RN #1) was interviewed about Resident #1 without signs indicating contact precautions. RN #1 stated the contact isolation signs should have been posted when the resident moved into the room. The facility's policy titled Isolation - Categories of Transmission-Based Precautions (revised January 2012) documented concerning contact precautions, "...In addition to Standard Precautions, implement Contact Precautions for resident known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment...Signs - The facility will implement a system to alert staff to the type of precaution resident requires..." 5. On 10/8/20 at 10:15 a.m., the unit identified by staff as the designated quarantine unit for new	F 880	Since all other residents have the potential to be affected by the deficient practice an review of the isolation signage has been completed. The staff will be in-serviced on the types of isolation and about the signs and where to find them. All isolation signs will be filed in a red folder at the nurses's and made available to all Nurses. The Admission's Director will verify that the isolation is on the door when she places the resident's name outside the door. The Central Supply Clerk that stocks the isolation door racks or the isolation cart will verify that there is a sign on the door when she stocks. The type of isolation will be verified by the SDC. All the resident's on the Twinlake unit will be on "droplet isolation" unless otherwise determined by the DON or SDC. Any other resident rooms on isolation will be verified by the DON or SDC.	

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F 880	Continued From page 14 admissions/re-admissions was inspected. Three out of seven rooms with residents on this unit (53, 55 and 57) had isolation supply boxes mounted on the doors but no signs posted indicating what type of precautions or PPE were required when entering the room. The remaining four rooms with residents had signs indicating contact/droplet precautions and listed that gowns, gloves, face shield and a N95 mask were required prior to entering the room. On 10/8/20 at 10:30 a.m., the registered nurse (RN #2) working on the quarantine unit was interviewed. RN #2 stated no residents on the unit were COVID-19 positive but were on the unit for 14 days following an admission or readmission to the facility. RN #2 stated all residents on the unit were on droplet precautions and were monitored for any signs/symptoms of COVID-19 during the 14-day quarantine period. RN #2 stated if residents developed symptoms or tested positive they were moved to the COVID-19 isolation unit. On 10/8/20 at 10:40 a.m., the director of nursing (DON) was interviewed about the signs and precautions required on the quarantine unit. The DON stated all residents on the unit were on a 14-day quarantine that included droplet/contact precautions. The DON stated all staff members were supposed to wear the required PPE when in and out of resident rooms. On 10/8/20 at 10:55 a.m., the registered nurse infection preventionist (RN #1) was interviewed about the lack of signs on three rooms of quarantined residents. RN #1 stated all the residents on the unit were on droplet/contact precautions to be sure they did not have	F 880	The residents on the Twinlake "Isolation Unit" in rooms 53,55 and 57 isolation signs were put in place. Since all other residents have the potential to be affected by the deficient practice an review of the isolation signage has been completed. The staff will be in-serviced on the types of isolation and about the signs and where to find them. All isolation signs will be filed in a red folder at the nurses's and made available to all Nurses. The Admission's Director will verify that the isolation is on the door when she places the resident's name outside the door. The Central Supply Clerk that stocks the isolation door racks or the isolation cart will verify that there is a sign on the door when she stocks. The type of isolation will be verified by the SDC. All the resident's on the Twinlake unit will be on "Extensive Droplet Contact Isolation," unless otherwise determined by the DON or SDC. Random audits of the signage will be conducted and recorded. The results of the audit information will be discussed at the Risk Management meeting and at the QA meeting Monthly.	11- 2- 20

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F 880	Continued From page 15 COVID-19 prior being placed onto the standard units. RN #1 stated this required N95 masks, gowns, gloves and face shield when entering rooms. RN #1 stated signs were supposed to be posted on each room indicating the type of precautions and equipment required. RN #1 stated she did not know what happened to the infection control signs. The facility's policy titled Isolation - Categories of Transmission-Based Precautions (revised January 2012) documented concerning droplet precautions, "...In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganism transmitted by droplets (large-particle droplets...that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning...Signs - The facility will implement a system to alert staff and visitors to the type of precaution the resident requires..." The facility's COVID-19 Action Plan (September 2020) documented, "...All new and readmissions are placed on the quarantine unit in a room by themselves for 14 full days...Required PPE on Quarantine Units - N95 mask, Gown, Face shield, Gloves - Worn in resident rooms- N95 Masks in hallways..." These findings were reviewed with the administrator, DON and infection preventionist on 10/8/20 at 1:45 p.m. and on 10/9/20 at 11:45 a.m. 6. On 10/8/20 at 10:15 a.m., the unit identified by staff as the quarantine unit for new admissions/readmissions was inspected. A housekeeper was observed in Resident #2's	F 880	The housekeeper in Resident #2's room was instructed to put the items back in the residents room.	

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F 880	Continued From page 16 room operating a floor buffer. The housekeeper had on a mask but no gloves or gown. Signs posted on Resident #2's door listed the resident was on contact/droplet precautions and PPE (gown, gloves, face shield, N95 mask) was required when entering the room. Resident #2's room was empty with no furniture or personal belongings in the room. Stored in the hallway of the quarantine unit along the wall were two resident beds from the room. Two waste cans (one with red liner, one with white liner) were on top of one of the beds. Clothing, shoes, a suitcase, toiletries and personal belongings were piled on top of the other bed, uncovered. Two bedside tables were also in the hall along with bathroom items that included a bedpan. On 10/8/20 at 10:22 a.m., the housekeeper (other staff #3) was interviewed. The housekeeper stated he was stripping and waxing the floor in Resident #2's room. The housekeeper stated he moved all the room items prior to stripping/waxing the floor and placed them in the hallway. When asked where the resident was while he was waxing the floor, the housekeeper pointed to Resident #2 who was seated in a wheelchair in the hallway. The housekeeper stated Resident #2's room was on his schedule for routine floor waxing and he was not aware of anything different for rooms on contact/droplet precautions. On 10/8/20 at 10:30 a.m., the registered nurse (RN #2) caring for Resident #2 was interviewed about the displaced resident and her furnishings stored in the hall while on droplet precautions. RN #2 stated the residents on the unit were quarantined for 14 days following an admission/readmission to be sure they did not	F 880	Since all other residents have the potential to be affected by the deficient practice the managers will verify that there staff is wearing the correct PPE. The housekeeping staff will The housekeeping staff will be educated on not stripping and waxing rooms on the quarantine unit and/or any resident on isolation. They will also be informed not to place dirty items on a resident's bed. The housekeeping staff will be in-serviced on the proper PPE to wear and to pay attention to the the isolation signs that are on the door. The staff will be educated by the CDC "Put on and Take Off PPE" handout and U-tube video per the resources listed. They will also be in-serviced on "How to Protect Yourself and Others. The Housekeeping Supervisor will monitored that the housekeepers are wearing the correct PPE and the floor services executed to the rooms will be audited and monitored by the Housekeeping Supervisor.	11-02-20

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F 880	Continued From page 17	F 880		

have symptoms of COVID-19. RN #2 stated he did not know anything about waxing the floors or why the resident's furnishings/belongings were in the hallway.

On 10/8/20 at 11:00 a.m., accompanied by the registered nurse infection preventionist (RN #1), the furniture and room items stored in the hallway on the quarantine unit were observed. RN #1 was interviewed at this time about the floor stripping/waxing and displaced furnishings for a resident on droplet precautions. RN #1 stated she was not aware housekeeping was waxing floors on the quarantine unit and not aware the room furnishings were in the hallway.

On 10/8/20 at 11:05 a.m., the housekeeping supervisor (other staff #4) was interviewed. The housekeeping supervisor stated no one had informed him that he should not strip/wax floors on the quarantine unit. The housekeeping supervisor stated they routinely stripped/waxed two resident rooms per month. The housekeeper (other staff #3) joined the interview at this time. The housekeeper stated he had gloves and a mask on when he moved the furnishings/belongings from Resident #2's room but did not wear a gown.

On 10/8/20 at 11:15 a.m., the housekeeping supervisor stated he checked with his boss who stated as long as there were no active COVID-19 cases on the unit, the floor stripping/waxing was ok. When asked if there had been any discussion about routine waxing of a resident's room with droplet precautions in place, the housekeeping supervisor stated nobody had discussed this with him. The housekeeping supervisor stated the housekeeper should have

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F 880	Continued From page 18 worn a gown when moving personal belongings/furnishings from the room in addition to a mask and gloves. Resident #2's plan of care (revised 9/21/20) listed the resident required enhanced droplet isolation due to dialysis. The facility's policy titled Isolation - Categories of Transmission-Based Precautions (revised January 2012) documented concerning contact precautions, "...In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment...In addition to wearing gloves as outlined under Standard Precautions wear gloves (clean, non-sterile) when entering the room...do not touch potentially contaminated environmental surfaces or items in the resident's room...Wear a disposable gown upon entering the Contact Precautions room...After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces..." These findings were reviewed with the administrator, director of nursing and infection preventionist on 10/8/20 at 1:45 p.m. and on 10/9/20 at 11:45 a.m.	F 880		
F 886 SS=F	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	F 886	The LTC facility will test all residents and staff weekly after a COVID -19 out-break.	

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F 886	Continued From page 19 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; §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.	F 886	Since all residents have the potential to be affected by the deficient practice the facility will follow the CDC guidelines for testing and the positivity chart for the City of Lynchburg. All COVID-19 testing will be conducted per the CDC Guidelines. We will document the Lynchburg's area postivity rate. In the event there is a delay in test results we will document our efforts to contact the lab and the Local Health Department per the CDC Guidelines. All COVID-19 documentation will be maintained and reported on at our weekly Risk Meeting and then at the Monthly QA meeting.	11-02-20 11-02-20

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F 886	Continued From page 20 §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 and facility document review, the facility to perform COVID-19 testing every 3-7 days as required for a COVID-19 outbreak, for all residents and staff in the facility. Findings were: On 10/08/2020 at approximately 9:15 a.m., an entrance conference was held with the facility administrator. The following information was requested: Testing protocol in place, testing results to include number of residents and staff tested on what dates, and the county positivity rate. At approximately 9:30 a.m., the administrator reported that the county positivity rate as of 10/08/2020 was 8.5%. She was asked how often the facility was conducting testing. She stated,	F 886		

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F 886	Continued From page 21 "Our results are taking 7-10 days to get back...we have been directed on our COVID calls to not do testing until we get the previous results back." She was asked who had directed her and who was on the COVID calls. She stated, "That is from our Corporate office." She was asked when the last positive cases were in the facility. She stated, "...I'll need to get exact dates." At approximately 1:15 p.m., a meeting was held with the DON (director of nursing), the infection preventionist, and the administrator. It was reported that one staff member had tested positive for COVID-19 outside of the facility on 09/13/2020. The facility tested 92 staff and 84 residents on 09/15/2020 with 100 % negative results. On 09/17/2020, one resident became symptomatic with shortness of breath and POC testing was conducted onsite with a positive result. Testing was conducted on 09/22/2020 of 96 staff and 85 residents with all negative results. The administrator stated, "We did not do any testing again until this week since we didn't have our results. We tested 86 staff members on October sixth and 83 residents on October seventh. We don't have those results back." An email between the administrator and the corporate office dated 09/21/2020 was presented. It contained the following: "...Unfortunately, we have not received our COVID Results back this weekend as promised. As of this email, we still have not received any test results. I personally called [name of lab] this morning who is only saying that they are back logged and cannot provide me a time frame. Are we still supposed to do our weekly testing, even though, we have Not received any test results back? Please clarify as my understanding is that we need to wait for	F 886		

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results before we complete another round of testing. [Name] from the local Health Department was notified that we are still waiting for results. Please advise." The email was signed by the administrator. The response from the corporate office on 09/22/2020 was: "You need to wait and test symptomatic residents and staff only via poc machine as discussed on the call last week."

On 10/09/2020 at approximately 9:25 a.m., the administrator was interviewed. She was asked if the facility had documented ongoing attempts to obtain test results in a timely manner. She stated, "We called the health department and the lab. I can get somebody to write it down." The facility policy, "Coronovirus Testing" was discussed. On page 2 under the section "Testing of Staff and Residents in Response to an Outbreak", the policy contained the following:

"1. All staff and residents will be tested upon identification of a single new case of COVID-19 infection in any staff or residents.

2. All staff and residents that test negative will be retested every 3 days 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."

The administrator was asked if the facility should have tested every 3-7 days according to their policy in response to the positive staff member on 09/13 and the positive resident on 09/17. She stated, "Corporate has interpreted the guidance from CMS on page 10 of the QSO letter as we shouldn't test until we get our results back."

The administrator also presented the following

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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 23	F 886		

letter from the lab used for testing. The letter was dated 10/08/2020 contained the following: "...during the month of September SARS-COV-19 results for the patients at your facility were delayed on several occasions and for that we apologize and appreciate your patience, as I know it directly affects patient care. Unfortunately. [Name], the manufacturer of the SARS COVID assay we use was unable to consistently supply our laboratory with the needed supplies to perform the assay. We have added 2 testing platforms to our menu so moving forward we will not be dependent on one manufacturer for supplies and results can be completed in the required time frame. As you did during this time frame when requesting the test results for you facility and an explanation for the delay please call the laboratory at [number] if you have any questions or concerns. Thank you again." The letter was addressed to the administrator and signed by the Director of Laboratory Services.

An exit conference was conducted on 10/09/2020 at approximately 11:45 a.m., with the DON, the administrator and the infection preventionist. The administrator was asked if there was any further documentation regarding attempts to get testing results in a timely manner. She stated, "At this point it won't change the outcome. I chose not to pursue it." Concerns were voiced regarding the lapse of testing from 09/22/2020 to 10/07/2020. Per regulation and the facility policy when an outbreak occurs, testing should be conducted every 3-7 days. At a minimum testing should have been completed on 09/29/2020 and 10/06/2020 for residents and staff members.

No further information was obtained prior to the exit conference on 10/09/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495151	A. BUILDING _____ B. WING _____	10/09/2020

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