STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495384	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCIS MARION MANOR HEALTH & REHABILITATION	100 FRANCIS MARION LANE, MARION, VA 24354

(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 6/22/20 through 7/01/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted 6/22/20 through 7/01/20. Corrections are required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). On 6/22/20, the census in this 109 certified bed facility was 83. Of the current 83 residents, 9 residents have been tested and were negative for COVID-19. 9 staff members and 9 students have been tested with one positive result.	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. §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:	F 880		8/1/20

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

Electronically Signed | 07/31/2020

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 §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. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 2 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 observations, staff interviews and facility document review, and during the course of a COVID-19 focused survey, it was determined the facility staff failed to consistently implement infection control plans/practices designed to attempt to prevent the development and/or transmission of COVID-19. The findings included: The facility staff failed to provide specific PPE (personal protective equipment) signage posted outside of (2) resident's rooms (Resident #1 and Resident #2). On 6/22/2020 at 4:15 pm, the surveyor and administrator conducted a walking tour of the nursing facility. During this tour, the surveyor noted over the door PPE for Resident #1 and #2's rooms. There was no signage to inform the staff of the appropriate PPE to be used while caring for the residents in these rooms. The surveyor asked the administrator if appropriate signage should be on the resident's door alerting the staff the type of isolation the resident was on and what type of PPE was required to be used by the staff	F 880	Posting specific PPE (personal protective equipment) signage outside of resident rooms is important to the team at FMM 1. Appropriate signage was placed outside of the rooms for Residents #1 and #2. 2. Any resident who requires isolation could be affected by the same deficient practice. And audit of all seven rooms for residents who are currently on isolation precautions was conducted to ensure appropriate signage is in place. 3. The charge nurse will be responsible for placing signage at the time isolation hangers and will ensure signage is included. 4. An audit will be conducted to ensure appropriate isolation precaution signage is visible at the door along with PPE four times weekly for six weeks and then four times monthly for six months for all rooms.	

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F 880	Continued From page 3 caring for the residents. The administrator stated, "Yes there should be a sign on both of these rooms." The administrator informed the DON (director of nursing) of the above documented findings. On 7/1/2020, the surveyor reviewed the facility's policy titled "Infection Control" which read in part" ...Signage shall be posted at the first point of encounter with instruction to Residents and Team Members to take appropriate control measures ..." No further information was provided to the surveyor prior to the exit conference on 7/1/2020.	F 880	5. Corrective action will be completed as of August 1, 2020 Directed Plan of Correction: 1. Evidence of current infection control policy and procedure will be attached. 2. Training residents and staff regarding social distancing and wearing a face mask is ongoing, starting at the beginning of the pandemic. Evidence of the trainings will be attached. 3. Training appropriate staff regarding implementing appropriate transmission based precautions for COVID-19, including PPE to be used. Evidence of the trainings will be attached. 4. A Root Cause Analysis was conducted and presented to Infection Prevention, the QAPI team and Governing body. The RCA was used in the Plan of Correction, with specific interventions gleaned from conducting the RCA. The RCA will be attached.	