STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495309	A. BUILDING _____ B. WING _____	12/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH NORFOLK	827 NORVIEW AVENUE NORFOLK, VA 23509

(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 onsite 12/08/20 and continued with offsite review through 12/11/20. 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 COVID-19 Focused Survey was conducted onsite 12/08/20 and continued with offsite review through 12/11/20. The facility was not in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. No complaints were investigated during the survey. The census in this 60 certified bed facility was 43 at the time of survey. Twenty-four Residents had tested positive for COVID-19, four had been hospitalized and one resident remained hospitalized. Five staff had tested positive for COVID-19, one staff had returned to work.	F 000		
F 552 SS=E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.	F 552	This plan of correction does not constitute either an admission or concession of the existence, scope or significance of any alleged deficiencies. Rather, it constitutes actions taken and recorded to comply with federal regulations. This plan of correction is submitted as our allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/31/20

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 552	Continued From page 1 §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, and clinical record review, the facility's staff failed to inform three resident (Resident #2, 3 and 7), out of 10 residents in the survey sample, of their COVID-19 laboratory results. The findings included: 1. Resident #2 was originally admitted to the facility 10/26/20. The current diagnoses included; renal insufficiency and diabetes. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/29/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were intact. The resident was identified by the facility's Social Worker as her own responsible party. On 12/8/20 at approximately 12:12 p.m., an interview was conducted with Resident #2. Resident #2 stated it had not been officially reported to her but she overheard staff in the	F 552	F 552 Right to be Informed/Make Treatment Decisions 1. Residents #2, #3 and #7 were informed of their individual covid testing results on 12/10/20, 12/16/20 and 12/31/20. They were also informed of the covid outbreak status of the facility on this date. 2. All residents are at risk from this deficient practice. 3. Staff education was provided to licensed professional nursing staff regarding the elements of F Tag 552 and requirements to keep residents informed of their health care status 12/10/20, 12/14/20, 12/28/20 and 12/31/20. The providers were also included in this education. 4. The DON or designee will audit the 24-hour report 3 X weekly to assure any changes in condition or health status updates are communicated to the residents timely. Results of these audits will be communicated to the QAPI committee for additional oversight and any recommended changes to the plan. 5. Date certain: 01/25/2021	

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F 552	Continued From page 2 hallway stating there were eight more COVID-19 positive residents in the facility and it was concerning. Resident #2 also stated she had been tested three times for COVID-19, including 12/7/20 and not one time had staff informed her of the test results. Review of Resident #2's clinical record on 12/10/20, revealed no documentation the resident was informed of any COVID-19 test results. The following COVID-19 progress note were documented in her clinical record: 12/6/2020 12:15 Communication with Family/POA/Responsible Party Note Text: On November 30, 2020 I called regarding the testing results of the facility and made them aware that we have both positive patients and employees. 2. Resident #3 was originally admitted to the facility 3/25/20. The current diagnoses included; anemia and schizophrenia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/30/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. The resident was identified by the facility's Social Worker as his own responsible party. On 12/8/20 at approximately 12:17 p.m., an interview was conducted with Resident #3. Resident #3 stated his roommate was sick and he suspected it was the virus everyone is talking about. Resident #3 stated he had been tested twice for COVID-19 yet; no one informed him of the results of his very own test.	F 552		

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F 552	Continued From page 3 Review of Resident #3's clinical record revealed no documentation the resident was informed of his COVID-19 test results but; the following progress notes were present: 12/4/2020 10:12 Nursing Progress Note Note Text: resident had room change to 209 related to roommate tested positive to COVID 19. Resident awake alert and verbal no signs/symptoms of COVID 19 temp. 98.1. no signs/symptoms of acute distress noted. 12/4/2020 22:35 eMar - Shift Level Administration Note Note Text: resident had room change to isolation unit no signs/symptoms of acute distress noted no cough or congestion noted. temperature 98.1, resident adjusting well. 3. Resident #7 was originally admitted to the facility 2/14/20. The current diagnoses included; diabetes and vascular disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/22/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. The resident was identified by the facility's Social Worker as his own responsible party. On 12/8/20 at approximately 12:25 p.m., an interview was conducted with Resident #7. Resident #7 stated after going out to the foot doctor last Tuesday, he was moved to the current room. The resident stated no one had given him any information about the three COVID-19 test he had completed. Resident #7 stated "I figured I don't have it".	F 552		

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F 552	Continued From page 4 Review of Resident #7's clinical record revealed no documentation the resident was informed of any COVID-19 test results but; the following progress note was present: 12/2/2020 13:11 eMar - Shift Level Administration Note Note Text: isolated per Centers for Disease Control guidelines. On 12/10/20 at approximately 2:20 p.m., the above findings were shared with the Executive Director and the Director of Clinical services. The Director of Clinical services stated it is the licensed nurse staff responsibility to inform residents of laboratory results. No additional information was provided. Facility documentation revealed one resident tested positive for COVID-19 at the hospital on 11/23/20. Another resident tested positive at the facility 11/25/20. All residents were tested for COVID-19 on 11/25/20, secondary to three staff member testing positive for COVID-19 infections on 11/25/20, also one resident tested COVID-19 positive on 11/25/20. On 11/28/20 two more staff members tested positive for COVID-19. On 11/28/20 and 11/29/20, the resident's test results from the 11/25/20, testing arrived to the facility. The test results revealed four more residents were COVID-19, positive. All residents were retested 11/29/20 and the results were made available to the facility 12/1/20. The results revealed four residents were COVID-19 positive and another resident presented with acute COVID-19 symptoms and was transferred to the hospital. On 12/4/20 three additional residents presented with signs of COVID-19 and tested positive. On 12/5/20 one resident presented with	F 552		

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F 552	Continued From page 5 signs of COVID-19 and tested positive for COVID-19. On 12/7/20, six residents presented with acute COVID-19 symptoms; they tested positive for COVID-19 therefore all residents were retested for COVID-19 and results were pending return from the lab.	F 552		
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: §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	F 880	F 880 Infection Prevention and Control 1. The improper removal of soiled linen from a resident room was observed. No immediate correction is possible. The improper application of PPE for C.NA #1 was observed. No immediate correction is possible. 2. All residents are at risk from this deficient practice. 3. The LPTA received remedial education regarding the proper storage and disposal of soiled linen on 12/10/2020. C.NA # 1 received remedial education regarding the proper application of a disposable gown with all ties tied, and the wearing/changing of PPE on 12/10/2020. Education was additionally provided to all staff regarding proper removal of soiled linen from resident rooms and proper use of PPE 12/28/20 and ongoing. 4. The DON or designee will 3 X weekly to assure prevention control techniques are being implemented consistently. Results of these audits will be communicated to the QAPI committee for additional oversight and any recommended changes to the plan. 5. Date certain: 01/25/2021	

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F 880	Continued From page 6 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 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, clinical record review, and staff interviews the facility's staff failed to ensure infection control measures were	F 880		

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F 880	Continued From page 7 consistently implemented to prevent the development and/or transmission of a communicable disease (COVID-19), and other infectious diseases. The findings included; 1. On 12/8/20, at approximately 11:57 a.m., a Licensed Physical Therapist Assistant (LPTA) was observed coming out of a quarantined resident's room with wet linen in his left ungloved hand and a red ball in the right hand. LPTA look around in the hallway and returned inside the resident's room with the linen. An interview was conducted with LPTA on 12/10/20 at approximately 4:55 p.m. The LPTA stated there were no linen bags in the room therefore he brought the linen out to bag it, later returning to the room a plastic bag was removed from the trash can to bag the soiled linens. An interview was also conducted with the Rehabilitation Director on 12/10/20 at approximately 3:58 p.m. The Rehabilitation Director stated LPTA should have carried a linen bag into the room and the linen should have been bagged prior to bringing it out the room. The Rehabilitation Director also stated LPTA should have had gloves on and the LPTA had been educated on infection control protocols. 2. On 12/8/20, at approximately 1:04 p.m., Certified Nursing Assistant (CNA) #1 was observed on the COVID-19 quarantine unit wearing a gown that was not tied at the neck and a pearl necklace was swinging back and forth around the neck. CNA proceeded to enter the resident's room and closed the door. CNA #1	F 880		

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F 880	Continued From page 8 began gathering the meal trays from resident rooms at approximately 1:20 p.m. CNA #1 entered the rooms, went over to the bed table removed the container and trash and put the waste on the cart, then proceeded to the next room, entered, obtained the container and waste, place it on the meal cart and proceeded to the next room where the gown and gloves were removed prior to entrance, the hands were sanitized and new gloves applied. CNA #1 again entered the rooms, went over to the bed table removed the container and trash and put the waste on the cart, then proceeded to the next room, entered, obtained the container and waste, place it on the meal cart after-which the gown and gloves were removed, hands sanitized and a new gown and gloves were donned. An interview was conducted with CNA #1 at approximately 1:38 p.m. CNA #1 stated the gown and gloves should have been changed in between rooms since the residents were COVID-19 positive but she had only been working at the facility for four days. On 12/10/20 at approximately 2:20 p.m., the above findings were shared with the Executive Director and the Director of Clinical services. The Director of Clinical services stated it was true that it was CNA #1's fourth day working at the facility and she had been educated regarding infection control protocols as well as the LPTA. Documentation of both staff members infection control education was provided.	F 880		
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility	F 885		

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F 885	Continued From page 9 must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, clinical record review, and review of facility documents, the facility's staff failed to inform residents residing in the facility of confirmed infection of COVID-19, for 3 of 10 residents (Residents #2, #3 and #7), in the survey sample. The findings included: 1. Resident #2 was originally admitted to the facility 10/26/20. The current diagnoses included; renal insufficiency and diabetes.	F 885	F 885 Reporting-Residents, Representatives & Families 1. Residents #2, #3 and #7 were informed of the covid outbreak status of the facility on 12/16/20. 2. All residents are at risk from this deficient practice. 3. Staff education was provided to licensed professional nursing staff regarding the elements of F Tag 885 and requirements to notify residents and their representative or family by 5 pm the next calendar day. This includes mitigating actions the facility is taking to protect them. The census of the facility will be assigned to Department leaders to provide updates as necessary and by 5 pm the next calendar day. Notes will be added to PCC to confirm contact was completed. 4. The Administrator or designee will audit the 10% of resident records weekly to assure notifications are being made and documented. Results of these audits will be communicated to the QAPI committee for additional oversight and any recommended changes to the plan. 5. Date certain: 01/25/2021.	

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F 885	Continued From page 10 The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/29/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were intact. The resident was identified by the facility's Social Worker as her own responsible party. On 12/8/20 at approximately 12:12 p.m., an interview was conducted with Resident #2. Resident #2 stated she had recently been moved to that room because the facility needed the previous room for another resident. Resident #2 further stated it had not been officially reported to her but she overheard staff in the hallway stating there were eight more COVID-19 positive residents in the facility and it was concerning. Resident #2 also stated on one occasion her sister was contacted by the facility of confirmed COVID-19 infections in the facility. Review of Resident #2's clinical record revealed no documentation the resident was informed of new confirmed cases of COVID-19 in the facility by 5:00 p.m., the day after the information was available to the facility's staff but; the following progress notes were present: 12/6/2020 12:15 Communication with Family/POA/Responsible Party Note Text: On November 30, 2020 I called regarding the testing results of the facility and made them aware that we have both positive patients and employees. 12/10/2020 17:14 Health Status Note Note Text: Spoke with resident. Notified resident that her	F 885		

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F 885	Continued From page 11 COVID-19 results were negative. Informed resident that facility will continue to perform weekly testing on all residents. Resident verbalized understanding. 2. Resident #3 was originally admitted to the facility 3/25/20. The current diagnoses included; anemia and schizophrenia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/30/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #3's cognitive abilities for daily decision making were intact. The resident was identified by the facility's Social Worker as his own responsible party. On 12/8/20 at approximately 12:17 p.m., an interview was conducted with Resident #3. Resident #3 stated his roommate was sick and he suspected it was the virus everyone is talking about but no one informed him of the virus situation in the facility or the results of his very own test. Review of Resident #3's clinical record revealed no documentation the resident was informed of new confirmed cases of COVID-19 in the facility by 5:00 p.m., the day after the information was available to the facility's staff but; the following progress notes were present: 12/4/2020 10:12 Nursing Progress Note Note Text: resident had room change to (room number) related to roommate tested positive to	F 885		

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F 885	Continued From page 12 COVID 19. Resident awake alert and verbal no signs/symptoms of COVID 19 temp. 98.1. no signs/symptoms of acute distress noted. 12/4/2020 22:35 eMar - Shift Level Administration Note Note Text: resident had room change to isolation unit no signs/symptoms of acute distress noted no cough or congestion noted. temperature 98.1, resident adjusting well. 3. Resident #7 was originally admitted to the facility 2/14/20. The current diagnoses included; diabetes and vascular disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/22/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making were intact. On 12/8/20 at approximately 12:25 p.m., an interview was conducted with Resident #7. Resident #7 stated after going out to the foot doctor last Tuesday, he was moved to the current room. The resident stated he likes the room and hopes to remain there. Resident #7 further stated he's fully aware of the virus because that's all on the television. Resident #7 also stated he knows a mask must be worn if he leaves the room but no one in the facility had offered information about cases in the facility and no one had given him any information about the three COVID-19 test he had completed. "I figured I don't have it". The resident was identified by the facility's Social Worker as his own responsible party.	F 885		

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	495309	A. BUILDING _____ B. WING _____	12/11/2020

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F 885	Continued From page 13 Review of Resident #7's clinical record revealed no documentation the resident was informed of new confirmed cases of COVID-19 in the facility by 5:00 p.m., the day after the information was available to the facility's staff but; the following progress note was present: 12/2/2020 13:11 eMar - Shift Level Administration Note Note Text: isolated per Centers for Disease Control guidelines. On 12/10/20 at approximately 10:30 a.m. an interview was conducted with the Receptionist. The Receptionist stated she contacted 95% of the residents Responsible Parties to provide an update of the facility's COVID-19 status for the dates of 11/30/20 and 12/5/20. The Receptionist further stated documentation was not made in the residents records until 12/6/20. On 12/10/20 at approximately 2:20 p.m., the above findings were shared with the Executive Director and the Director of Clinical services. The Director of Clinical services stated there may be some documentation concerns. No additional documentation was provided which indicated residents, their representatives, and families of those residing in facilities by 5 p.m. were notified by the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. An interview was conducted with the Social Worker on 12/10/20 at approximately 4:05 p.m. The Social Worker stated under normal circumstances, notifications related to COVID-19 were her responsibility but during the specified	F 885		

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F 885	Continued From page 14 time span she was out sick with COVID-19. Facility documentation revealed one resident tested positive for COVID-19 at the hospital on 11/23/20. Another resident tested positive at the facility 11/25/20. All residents were tested for COVID-19 on 11/25/20, secondary to three staff member testing positive for COVID-19 infections on 11/25/20, also one resident tested COVID-19 positive on 11/25/20. On 11/28/20 two more staff members tested positive for COVID-19. On 11/28/20 and 11/29/20, the resident's test results from the 11/25/20, testing arrived to the facility. The test results revealed four more residents were COVID-19, positive. All residents were retested 11/29/20 and the results were made available to the facility 12/1/20. The results revealed four residents were COVID-19 positive and another resident presented with acute COVID-19 symptoms and was transferred to the hospital. On 12/4/20 three additional residents presented with signs of COVID-19 and tested positive. On 12/5/20 one resident presented with signs of COVID-19 and tested positive for COVID-19. On 12/7/20, six residents presented with acute COVID-19 symptoms; they tested positive for COVID-19 therefore all residents were retested for COVID-19 and results were pending return from the lab.	F 885		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement	F 886		

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F 886	Continued From page 15 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. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms	F 886	F 886 Covid 19 Testing-Residents and Staff 1. Results of covid testing for residents #2, #3 and #7 were documented in their perpective records on 12/25/20. Residents involved will be monitored for any signs of infection. 2. All residents are at risk from this deficient practice. 3. Staff education was provided to licensed professional nursing staff regarding the elements of F Tag 886 requiring documentation of results in the resident's clinical record. The medical records clerk or designee will upload testing results to the clinical records weekly. 4. The Administrator or designee will audit the 10% of resident records weekly to assure covid testing results have been documented. Results of these audits will be communicated to the QAPI committee for additional oversight and any recommended changes to the plan. 5. Date certain: 01/25/2021	

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F 886	Continued From page 16 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 interviews, and clinical record review, the facility's staff failed to file in the resident's clinical record COVID-19 laboratory results for 3 of 3 residents, (Resident #2, #3, and #7) in the survey sample. The findings included; Facility documentation revealed one resident tested positive for COVID-19 at the hospital on 11/23/20. Another resident tested positive at the facility 11/25/20. All residents were tested for COVID-19 on 11/25/20, secondary to three staff member testing positive for COVID-19 infections on 11/25/20; also one resident tested COVID-19 positive on 11/25/20. On 11/28/20 two more staff members tested positive for COVID-19. On 11/28/20 and 11/29/20, the resident's test results from the 11/25/20, testing arrived to the facility. The test results revealed four more residents were COVID-19 positive. All residents were retested 11/29/20 and the results were made	F 886		

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F 886	Continued From page 17	F 886		

available to the facility 12/1/20. The results revealed four residents were COVID-19 positive and another resident presented with acute COVID-19 symptoms and was transferred to the hospital. On 12/4/20 three additional residents presented with signs of COVID-19 and tested positive. On 12/5/20 one resident presented with signs of COVID-19 and tested positive for COVID-19. On 12/7/20, six residents presented with acute COVID-19 symptoms. They tested positive for COVID-19 therefore; all residents were retested for COVID-19 and results were pending return from the lab.

1. Resident #2 was originally admitted to the facility 10/26/20. The current diagnoses included; renal insufficiency and diabetes.

The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/29/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15.

Resident #2 was identified as her own responsible party.

On 12/8/20 at approximately 12:12 p.m., an interview was conducted with Resident #2. Resident #2 stated she had been tested three times for COVID-19, including 12/7/20.

Review of Resident #2's clinical record revealed no laboratory results or written documentation indicating that COVID-19 testing was offered, completed or not completed and the results of each completed test.

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F 886	Continued From page 18 2. Resident #3 was originally admitted to the facility 3/25/20. The current diagnoses included; anemia and schizophrenia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/30/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. Resident #3 was his own responsible party. On 12/8/20 at approximately 12:17 p.m., an interview was conducted with Resident #3. Resident #3 stated he had been tested twice for COVID-19. Review of Resident #3's clinical record revealed no laboratory results or written documentation indicating that COVID-19 testing was offered, completed or not completed and the results of each completed test. 3. Resident #7 was originally admitted to the facility 2/14/20. The current diagnoses included, diabetes and vascular disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/22/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. Resident #7 was his own responsible party. On 12/8/20 at approximately 12:25 p.m., an interview was conducted with Resident #7. Resident #7 stated he had been tested three times for COVID-19, prior to the 12/7/20 test. Review of Resident #7's clinical record revealed	F 886		

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F 886	Continued From page 19 no laboratory results or written documentation indicating that COVID-19 testing was offered, completed or not completed and the results of each completed test. On 12/10/20 at approximately 2:20 p.m., the above findings were shared with the Executive Director and the Director of Clinical services. The Director of Clinical services stated the laboratory results are faxed to the fax machine in the nurse's station, the licensed nurses are responsible for picking up the labs, and placing the lab results in the physician's folder for review. She stated after the physician reviews the labs they are forwarded to Medical Records to be filed in the clinical record. The Director of Clinical services stated they identified the laboratory concern 12/8/20 and put a Plan of Correction (POC) in place. The plan was provided 12/11/20. It stated effective 12/9/20 Medical Records and Business Office staff will be educated. On Monday, Wednesday and Friday the Unit Manager would print all labs and place them in medical records to be uploaded into the medical record. The POC didn't include a signature page stating the identified staff had been education to meet compliance. The Executive Director stated within 2-4 days Medical Records has the laboratory results in the clinical record but there was room for improvement. As of 12/10/20, there were no COVID-19 laboratory results on the resident's clinical record.	F 886		

COMMONWEALTH of VIRGINIA

Department of Health

M. NORMAN OLIVER, MD, MA
STATE HEALTH COMMISSIONER

Office of Licensure and Certification

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TYY 7-1-1 OR
1-800-828-1120

December 23, 2020

Pelican Health Norfolk Survey Results
Cycle Start Date: 12/11/2020

Infection Control Directed Plan of Correction (DPOC)

Imposed in accordance with 42 CFR § 488.424

Timeframe

- This DPOC must be completed no more than 21 days from the date of this letter or a DDPNA will be imposed on day 30.
- You must submit your DPOC within 15 days of the date of this letter.
- Your DPOC will not be accepted until the evidence/documentation asked for is received.
- If you encounter problems in completing this DPOC within the prescribed timeframe, notify the State Survey Agency promptly.
- A revisit will not be conducted or compliance achieved until this DPOC is completed.

Steps That Must Be Taken

1. Provide evidence of current infection control policy & procedures, including the guidance related to COVID-19 from the CMS and the U.S. Centers for Disease Control and Prevention.

2. Training of all nursing and rehabilitation staff regarding appropriate PPE use and linen handling. Include documentation of the training completed with a timeline for completion.

3. Conduct a Root Cause Analysis (RCA) that will be done with assistance from the Infection Preventionist, Quality Assurance and Performance Improvement committee and governing body. The RCA should be incorporated into the intervention plan.

Exit Summary with Scope and Severity Grid

Instructions: The team leader will fill out this form after each survey and email it to the supervisor.

Provider Name: Pelican Health - Norfolk **Survey Dates:** 12/08/20 - 12/11/20

Exit Time: 10:30 a.m.

Team Coordinator's Name: V. Kelly **Was a Licensure survey conducted?** No

Provider Number: 49-5309 **Enter entrance time if 10%er:** N/A

Tags cited:

(J)	**(K)**	**(L)**
(G)	**(H)** F552-VK	**(I)**
(D) F-880 (VK)	**(E)** F-885 (VK); F-886 (VK)	**(F)**
(A)	**(B)**	**(C)**

#of Tags to be written and by which inspectors:

Complaints:

0 Total # of complaints investigated during the survey.

0 # substantiated, with deficiencies; 0 # unsubstantiated, with deficiencies.

0 # substantiated, with no deficiencies; 0 # unsubstantiated, with no deficiencies.

List the MFI responsible, Complaint number, and Allegation number for each complaint. Example: CS VA0004321-#1=U, #2=S, #3=U, #4=S. In addition, if any complaint was received while onsite and did not have a number, please identify that complaint in some fashion

Administrator's Name: Jacynth Gray

Administrator's Email: jgray@pelicannorfolk.com

The facility IS registered for ePOC

(**NOTE:** The facility may have up to four registered users but only one registered user is needed for this form. ePOC will automatically grant access to all registered users)

ePOC registered user's name:

ePOC registered user's email address:

The facility is NOT registered for ePOC

Email address: jgray@pelicannorfolk.com

Alternate email address: