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E 000	Initial Comments An unannounced abbreviated Emergency Preparedness COVID-19 Focused Survey was conducted offsite on 4/28/2020, and both offsite and onsite 4/29/2020 through 5/11/2020. 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 abbreviated COVID-19 Focused Survey was conducted offsite on 4/28/2020, and both offsite and onsite 4/29/2020 through 5/11/2020. Significant corrections are required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). A complaint was investigated during the survey. The census in this 120 certified bed facility was 109 at entrance. Of the 109 current residents, 59 residents had tested positive for the COVID-19 virus. The survey sample consisted of ten current resident reviews (Residents #1 through #7, and #13 through #15), and five closed record reviews (Residents #8 through #12). On 4/29/2020 at 6:40 p.m., immediate jeopardy was called; the facility was notified on 4/30/2020 at 10:42 a.m. On 5/8/2020 at 1:18 p.m., immediate jeopardy was abated, and was lowered to a level 2 pattern.	F 000		
F 880 SS=K	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	F 880		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/27/2020

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F 880	Continued From page 1 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 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	F 880		

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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 observation, resident interview, staff interview, interviews with local health-department staff, review of facility documents, and clinical record review, it was determined, that the facility staff failed to ensure the implementation of infection control practices and precautions, to prevent the spread of infection, and communicable disease during an identified outbreak of Coronavirus (COVID 19), on one of two facility units, (South unit), and for five of 15 sampled residents, [Residents #3, #13, #2, #5, and #14].

The facility staff was not observed implementing standard and droplet precautions to prevent the spread of COVID 19 while providing care and services to COVID positive and negative residents, on the South unit. The facility staff

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failed to pull privacy curtains the full length of the bed in five of ten resident rooms in which COVID positive and negative residents resided together in the same room, resident room numbers, #220, #210, #206, #225, and #224.

The director of nursing, ASM (administrative staff member) #2 failed to implement droplet precautions when caring for a COVID-19 positive and a COVID-19 negative resident. ASM #2 failed to wear gloves and a gown when putting an arm around Resident #3, who was COVID-19 positive. ASM #2 then sanitized her hands with alcohol gel and, without donning gloves or a gown, walked over to Resident #13, who was COVID-19 negative, put an arm around Resident #13, and assisted Resident #13 down the hall.

The facility failed to implement droplet precautions by failing prevent Resident #3 and Resident #2, both COVID positive residents from wandering on the South unit without masks or PPE (personal protective equipment) (2). Resident #3, who was COVID-19 positive, was observed sitting at a table in common area accessible to both COVID 19 positive and negative residents.

In the hallway, Resident #2 was observed self-propelling in her wheelchair, within three feet of Resident #13, who was COVID-19 negative and not wearing a mask. In the common area, Resident #2 sat within three feet of Resident #5, who was COVID-19 negative.

As, a result of this failure, it was likely other residents were at risk of continued exposure and contracting COVID-19, which had already resulted in a COVID-19 positive status for over

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60% (59 residents) of the current 109 resident population at the time of the survey, with one resident death, (Resident #8), attributed to COVID-19. This failure resulted in Immediate Jeopardy.

On 5/5/2020, at approximately 2:00 p.m., the facility failed to prevent Resident #14 from wandering from a COVID-19 positive area on the South Unit, through a set of fire doors, and to a nurses' station located directly across from a room housing COVID-19 negative residents, resulting in a situation of continued Immediate Jeopardy.

In addition, the facility staff failed to implement infection control practice during incontinence care for one of 15 sampled residents, (Resident #15). The facility staff member failed to change gloves and to sanitize hands after cleansing Resident #15's perineal area (3) and handling the resident's soiled incontinence brief during incontinence care. Without cleaning hands or changing gloves, the staff member applied the resident's clean brief, helped pull the resident up in bed, and cleaned the resident's face with a wipe.

The State Agency informed the facility on 4/30/2020 at 10:42 a.m. of the Immediate Jeopardy situation. On 5/8/2020 at 1:18 p.m., the Immediate Jeopardy was abated and lowered to a level II Isolated.

The findings include:

1. On 4/28/2020, the survey team began an abbreviated, remote FICS (focused infection control survey) at the facility. As a part of the

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remote survey process, the survey team contacted and interviewed staff members from both the local and central health department.

On 4/28/2020 at 11:21 a.m., OSM (other staff member) #1 was interviewed. She stated that, to her knowledge, no member of the local or central VDH (Virginia Department of Health) had been inside the facility. She stated that when she was first informed of COVID-19 positive residents at the facility; she sent them copies of the state health department guidance for long-term care facilities. OSM #1 stated that she made a phone call to connect with ASM (administrative staff member) #3, the administrator, and ASM #2, the director of nursing. At that time, ASM #2 and ASM #3 described the facility's layout, and stated that in addition to one resident who had been hospitalized and tested positive for COVID-19, the facility had identified four additional residents as symptomatic. OSM #1 stated the facility staff told her they had begun to implement a plan to make the facility's dining room the COVID-19 ward. OSM #1 stated it was the next day that the facility-wide and staff-wide testing for COVID-19 was performed, and then the results started coming back over the next few days. OSM #1 stated that on Thursday, 4/23/2020, most all of the testing results had come back, indicating that over half the residents were COVID-19 positive, and 18 staff members were COVID-19 positive. She stated the facility then transferred 10 residents to the local hospital in an effort to, "basically isolate them." OSM #1 stated the facility transferred the residents to the hospital to "get them out of the facility and to stop the transmission" inside the nursing facility. OSM #1 stated that she recommended, at that time, that the facility "not try to do mass cohorting, as there

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were a significant number of COVID-19 positive residents on both units of the facility." When asked her professional response to the lack of mass cohorting of like residents, OSM #1 stated she had "mixed feelings." She stated that moving residents can be "disruptive" to them, and that there is a risk of exposure to other residents during a move. OSM #1 stated there was "some thinking" that COVID-19 negative residents had already been exposed to the virus if their roommate was COVID-positive. OSM #1 stated, "But I wonder how it is working in practice. I don't know the best way to assess if it is effective." She stated the best scenario would have been for COVID-19 positive residents to be placed with other positive residents, and vice versa for COVID-19 negative residents, but she was aware of "staff limitations" to implement fully the best scenario. OSM #1 stated the next best scenario would be to have the curtain pulled between residents, and for the staff to use different PPE (personal protective equipment) between residents. OSM #1 stated that her current understanding was that the facility was treating all residents as if they were COVID-19 positive.

On 4/28/2020, at 12:36 p.m., OSM #2, the director of the local health department, was interviewed. He stated that neither he nor any member of his staff had been inside the facility. OSM #2 stated one of his staff members had been up to the front door, but no further. When asked if he had any concerns about the way the facility was handling the outbreak, OSM #2 stated his concerns were about "maintaining the staff and the quality of care they are giving." OSM #2 stated, "I would not be horrified if you (State Survey Agency) made a site visit. But things seem to be better now than they were."

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On 4/28/2020, at 12:47 p.m., OSM #3, a nurse epidemiologist from the state health department was interviewed. When asked about any concerns that she had for the facility, OSM #3 stated, "They have a lot of COVID-19 there." OSM #3 stated the facility initially had a plan to use the dining room for COVID-19 positive patients, but she had expressed concerns to the facility staff about having adequate handwashing and toileting options available. OSM #3 stated the facility staff "abandoned that plan" because there were not enough staff members to do it. OSM #3 stated that once all facility residents had been tested and the results had come back, "it was a situation where you found a lot of asymptomatic, positive residents." She stated this created a concern about how to move residents and about how to staff the move. OSM #3 stated, "I can understand why they did not move or cohort residents. The staff was scared to come to work." OSM #3 stated, "We backed off and let the facility take the lead. It was safer for the situation they were in." OSM #3 stated she had emphasized to the facility the need to change gown and gloves between negative and positive patients.

On 4/28/2020 at 1:10 p.m., a phone interview was conducted with ASM #4, a nurse supervisor for the local health department. She stated she had been in the facility parking lot during the previous week, and had observed staff wearing PPE outside in the parking lot. She stated her concerns about the facility, were primarily related to PPE usage, and about "what kind of infection control is happening there."

On 4/29/2020 at 1:30 p.m., after the survey team entered the facility, ASM (administrative staff

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member) #1, the acting administrator, was interviewed about rooms, which housed both COVID-19 positive and COVID-19 negative residents. When asked how the staff knew which residents in a room were positive, and which residents, were negative for COVID-19, ASM #1 stated that resident nameplates had colored stickers. A pink sticker meant a resident was positive for the virus; a yellow sticker meant a resident was negative for the virus.

On 4/29/2020 at 1:40 p.m., an initial tour of the facility's South Wing was completed. The following room nameplates indicated that both a COVID-19 positive and a COVID-19 negative resident were housed in the same room: 220, 217, 214, 213, 210, 209, 206, 225, 224, and 223. In room 210, the curtain between the resident beds, was only pulled approximately 3/4 of way down the length of the beds. In rooms 220, 225, and 224, the curtain between resident beds was pulled approximately 1/2 way down the length of the beds. In room 206, the curtain between resident beds was not pulled at all.

On 4/29/2020, ASM (administrative staff member) #2, the director of nursing, was observed walking in hallway of the South Unit. ASM #2 was wearing a mask, but no gloves or gown. ASM #2 approached Resident #3, who was not wearing a mask, and who was walking down the hall. ASM #2 put her right arm around Resident #3's shoulders, and guided Resident #3 back towards her room. ASM #2 sanitized her hands with alcohol gel. Still without gloves or gown, ASM #2 approached Resident #13, who was not wearing a mask, and who was standing still in the hallway near the nurses' station. ASM #2 put her right arm around Resident #13's shoulders, and

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walked with Resident #13 all the way to the resident's room.

On 4/29/2020 at 3:45 p.m., Resident #3 was observed sitting alone at a table in the common area. She was not wearing a mask. While no other residents were observed in the area at this time, this common area was accessible to any resident on the South Unit.

On 4/29/2020 at 4:00 p.m., LPN (licensed practical nurse) #1 walked into the common area where Resident #3 was sitting. LPN #1 was wearing mask, gown, and gloves. She approached Resident #3, and invited the resident to walk with her down the hall and to return to her room. When asked why she was inviting the resident to go back to her room, LPN #1 stated, "She is one of the ones that is hard to keep in her room." LPN #1 stated the resident had been "pretty compliant" that day, and had three masks in her room. When asked why it was important for Resident #3 to wear a mask and to remain in her room, she stated the resident was at risk of spreading the COVID-19 virus.

Review of the clinical records for Resident #3 and #13, remotely, revealed Resident #3 was admitted to the facility on 2/28/20 with diagnoses including, but not limited to, COPD (chronic obstructive pulmonary disease) (4), dementia (5), and history of cancer. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 3/30/2020, the resident was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was coded as being independent for walking in her room and moving around on the

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unit. A review of Resident #3's nurse notes revealed a note on 4/23/2020 stating that she tested positive for COVID-19. A review of Resident #3's care plan dated 2/28/20 and updated 4/27/2020 revealed, in part: "Droplet isolation precautions (6) from COVID-19...Keep resident in room...Staff to wear PPE (personal protective equipment) at all times and maintain good hand hygiene...Behavior wandering - The resident is an elopement risk/wanderer r/t disoriented to place, impaired safety awareness, wanders aimlessly due to dementia...distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book."

Further review of Resident #3's clinical record revealed the following nurse note dated 4/25/2020: "Resident was given a mask for protection. Resident is confused and may take off and refuse mask."

Further review of Resident #3's clinical record revealed the following nurse note dated 4/26/2020: "Resident was given a mask for protection. At this time resident has mask on, but resident has advanced dementia and may take it off."

Resident #13 was admitted to the facility on 6/6/19; diagnoses include, but not limited to Alzheimer's disease (7), COPD, heart failure, and psychotic disorder (8). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 3/28/2020, Resident #13 was coded as having severe impairment for making daily decisions, having scored only six out of 15 on the BIMS. She was coded as being independent for walking in the

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room moving around the unit. A review of Resident #13's laboratory test results received by the facility on 4/23/2020 revealed that she tested negative for COVID-19.

A review of Resident #13's care plan, dated 6/21/19 and updated 4/27/2020 revealed, in part: "BEHAVIORS [Resident #13] was in a physical altercation with another resident. Potential for further altercations with others and staff due to dementia with behaviors...provide redirection or distraction to minimize frequency or duration of behavior...Resident at risk for cross infection r/t (related to) actual/potential exposure to COVID-19...Droplet isolation precautions from COVID-19...Initiate social distance of 6 feet away from resident unless giving care...Keep resident in room...Staff to wear PPE at all times and maintain good hand hygiene...BEHAVIOR/WANDERING - The resident is an elopement risk/wanderer related to Alzheimer's disease, known to wander when she was home...Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book...ALZHEIMER'S DISEASE - The resident has dementia causing impaired thought process r/t Alzheimer's...Cue, reorient, and supervise as needed...The resident needs supervision and assistance with all decision making."

On 4/29/2020 at 2:54 p.m., Resident #2 was observed sitting in a wheelchair in the common area watching television. Resident #2 was not wearing a mask. Resident #5 was observed sitting in a brown recliner watching television, and was within three feet of Resident #2. Resident #5 was wearing a mask. Resident #5 was asked his name and the location of the room. He answered

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the surveyor appropriately. When asked how often he watched television in the common area, he stated that he watched television "right much." When asked if he always wore a mask, Resident #5 stated, "Yes." An observation of this common area again at 3:05 p.m., revealed Resident #5 was no longer in the common area. Resident #2 remained there in her wheelchair, wearing no mask.

On 4/29/2020 at 3:12 p.m., Resident #2, who was COVID-19 positive and not wearing a mask, was observed self-propelling in her wheelchair, from the common area down the hall towards the nurses' station. As Resident #2 traveled down the hall, she passed within three feet of Resident #13, who was COVID-19 negative and not wearing a mask.

Review of the clinical records for Resident #2 and Resident #5 completed remotely, revealed Resident #2 was admitted to the facility on 12/31/10, and most recently readmitted on 12/24/19, with diagnoses including, but not limited to, COPD, diabetes (9) and schizoaffective disorder (10). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 4/21/2020, Resident #2 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as being independently mobile with supervision and the use of a wheelchair." A review of Resident #2's nurse notes revealed a note on 4/24/2020 stating that she tested positive for COVID-19.

Resident #2's comprehensive care plan, dated 1/11/11 and updated on 4/27/2020, revealed, in

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part the following: "Resident exhibits signs of alteration in respiratory status and at risk for cross infection due to positive test for COVID 29 (sic)...Droplet isolation precautions for COVID-19...Keep resident in room...Staff to wear PPE at all times and maintain good hand hygiene...The resident is able to propel herself independently in wheelchair at times, and other times requires supervision with occasional assistance...BEHAVIOR Noted with increased confusion. Resident refuses to wear face mask...Continue to encourage to wear face mask...Identify pattern of wandering: Is wandering purposeful, aimless or escapist? Is resident looking for something? Does it indicate the need for more assistance?...Cue, reorient, and supervise as needed."

Resident #5 was admitted to the facility on 5/27/14, and was readmitted on 12/23/19; diagnoses include, but are not limited to, history of a stroke and Parkinson's disease (11). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 1/15/2020, Resident #5 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS. Resident #5 was coded as requiring the help of one staff member for moving around the unit. He was coded as using a walker for mobility. A review of Resident #5's nurse notes revealed a note dated 4/24/2020 documenting that Resident #5 tested negative for COVID-19.

Review of Resident #5's comprehensive care plan, dated 5/7/14 and updated on 4/27/2020, revealed, in part the following: "Resident is at risk for cross infection r/t (related to)actual/potential exposure to COVID-19...Droplet precautions from

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COVID-19...Initiate social distance of 6 ft (feet) away from resident unless during care...Keep resident in room...THOUGHT PROCESS Potential for thought processes impaired d/t (due to) prior stroke...Cue, reorient and supervise as needed."

On 4/29/2020 at 4:02 p.m., ASM #1 was interviewed about the process staff followed for the decision to leave COVID-19 positive residents in the same rooms with COVID-19 negative residents. She stated that the facility had undergone testing for all residents and staff. ASM #1 stated that when the results of the testing came back, the results indicated, "Everyone had been exposed." She stated that at that time, the decision was made to leave all residents where they were, as more than 49 residents would have needed room changes to separate COVID-19 positive from COVID-19 negative residents. ASM #1 stated one of the facility's strategies of isolating COVID-19 positive from COVID-19 negative residents was to keep the curtain pulled between residents. She stated a staff member from the health department had instructed the facility to do this to maintain a barrier between COVID-19 positive and COVID-19 negative residents. When asked what it meant if the curtains were not pulled completely between COVID-19 positive and COVID-19 resident beds, ASM #1 stated the curtains should be pulled if both a COVID-19 positive and a COVID-19 negative resident were housed in the same room. When informed that interviews with the local health department had yielded information indicating that there was not enough staff to make resident room moves in order to separate COVID-19 positive and COVID-19 negative residents after the all-resident testing, ASM #1

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stated, "That is true - with 49 room moves and we had staff calling out." ASM #1 was informed that Residents #2 and #3, who were positive for COVID-19, were observed wandering the halls and common areas without a mask. ASM #1 stated, "Yes, we have given them masks. It is hard to keep them in their rooms, though." When asked the facility was still responsible to implement infection control precautions to prevent the spread of COVID-19 from positive to negative residents, ASM #1 stated, "Yes, they should stay in their room, and we keep giving them masks to use."

Review of the Line List for COVID-19 Outbreaks, submitted by the facility for review by fax on 4/29/20, revealed, the following documented entry for Resident #8:
- "Name of resident [Resident #8], Unit or Room, N [no], Onset Date, 4/24, Cough (Y/N), N, Fever (Y/N), N, Shortness of Breath (Y/N), N, SARS [severe acute respiratory syndrome] COV-2 test result (+/-), + [positive], Respiratory Panel Test Result (+/-), - [dash], Hospitalized (Y/N), N [no], Died (Y/N), 4/27." Under the section titled Notes: a + sign that was circled and handwritten note beside this documented, "COVID-19, with staff initials."

Resident #8 was admitted to the facility on 4/20/19 with diagnoses that include, but are not limited to COPD and heart failure. On the most recent MDS (minimum data set), an annual assessment with an assessment reference date of 4/20/2020, Resident #8 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). A review of Resident #8's clinical record revealed a nurse

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note dated 4/21/2020 documenting that the resident had tested positive for COVID-19. Further review revealed a nurse note dated 4/24/2020 documenting notification to the sons of the resident that the resident's condition had worsened. Further review revealed a nurse note dated 4/27/2020 documenting the resident's death at 2:37 p.m.

A review of the facility policy, "Isolation - Categories of Transmission-Based Precautions," revealed, in part: "Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others...Droplet Precautions...In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 microns in size] that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning)...Resident Placement (1) Place the resident in a private room if possible...When a private room is not available, residents with the same infection with the same microorganism but with no other infection may be cohorted. When a private room is not available and cohorting is not achievable, use a curtain and maintain at least 3 feet of space between the infected resident and other residents and visitors."

A review of the facility policy, "Outbreak of Communicable Diseases," revealed, in part: "Outbreaks of communicable diseases within the facility will be promptly identified and appropriately handled...The nursing staff will be

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responsible for initiating isolation precautions as directed or as necessary; and confining symptomatic residents to their rooms as much as feasible, when indicated."

A review of the facility policy, "Topic: Caring for the Resident with a Suspected or Confirmed Case of COVID-19," revealed, in part: "Residents with confirmed or suspected cases of COVID-19 will be cared for in accordance with guidelines as stipulated by the CDC. All efforts will be made to prevent transmission, treat symptoms, and provide necessary psychosocial support for infected resident (sic)...Patients with known or suspected COVID-19 will be transferred to the designated unit, and when feasible provided with a private room...Residents that have a confirmed case of COVID-19 can cohort with other residents who have a confirmed COVID-19...The following measures will be implemented for residents with known or suspected COVID-19: a facemask will be placed on the resident and worn as tolerated, transmission based precautions will be instituted to include placement of isolation cart at entrance of room and signage on the door, caregivers will don appropriate personal protective equipment (PPE) - gown, mask, face/eye shield, gloves."

A review of the facility's corporate document, "Rapid Response Plans in Event of Confirmed Infection," revealed, in part: "1. Triggering the Risk Management Team to coordinate response. Key Goals: Reduce morbidity and mortality, minimize disease transmission, protect healthcare personnel, preserve healthcare system functioning. 2. Activate COVID-19/Observation Unit Assessment for affected patient. Isolate patient...Facility works with local DOH (department of health) on federal

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F 880	Continued From page 18 recommendations." A review of the facility's policy, "COVID-19 (Coronavirus) revealed, in part: "This guidance is based on the currently available understanding of COVID-19-nCOV related to disease severity, transmission efficiency, and shedding duration which is crucial in understanding viral transmission and control...The virus' main means of spreading is thought to be person-to-person transmission. This includes, but is not limited to: people who are within about six feet of each other, respiratory droplets produced when an infected person coughs or sneezes. It can also be spread from contact with infected surfaces or objects...Preventative Measures...Patient Placement: Residents identified to have COVID-19 should be placed in an AIIR (Airborne Infection Isolation Room) or isolation room until transferred to a hospital or healthcare facility equipped with treating such infections and reported to local Board of Health." On 4/29/2020 at 4:30 p.m., after the onsite visit was completed, the long-term care supervisor was notified of the survey team's observations and a conference call was completed with two additional supervisors and the survey team. On 4/29/2020 at 6:49 p.m., it was determined that the facility's failure to implement infection control practices to prevent the spread of a communicable disease (COVID-19), resulted in a situation of IJ (immediate jeopardy). On 4/29/2020 at 7:02 p.m., the survey team attempted to contact the acting administrator of the facility, ASM #1. The survey team was informed that the administrator had left for the day.	F 880		

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On 4/30/2020 at 8:25 a.m., 8:44 a.m., 9:21 a.m., and 9:23 a.m., the survey team attempted to contact ASM #1, the acting administrator. On 4/30/2020 at 10:42 a.m., the administrator was reached by phone, and was informed of the concern for IJ. ASM #1 stated, "I knew it was going to be this." She stated, "the only way to fix this is to cohort the patients and round up the bodies to do this." ASM #1 was instructed to not begin moving residents or take any other action until the facility had submitted a POC (plan of correction), and the POC had been approved by the survey team and Long Term Care Supervisor.

On 4/30/2020 at 11:36 a.m., the surveyor received a call from OSM (other staff member) #1, the director of the local health department. OSM #1 stated he had received a "most disturbing" phone call from the CEO [chief executive officer] of the company that owns the facility. OSM #1 stated the CEO is "very upset" that they have received notification of some, sort of very bad, punitive measures that have financial implications. OSM #1 stated, "I thought we were clear about all of this." He stated, "I want to know what is going on," and asked what the facility CEO had been told. OSM #1 was informed that the only correspondence by the survey team, had been with ASM (administrative staff member) #1, a corporate staff member who is acting as the facility administrator and that ASM #1 had been informed of a concern for the facility's failure to implement infection control practices to prevent the spread of a communicable disease COVID-19. OSM #1 asked if the survey team was concerned because COVID-19 positive residents are in the same rooms with COVID-19 negative residents. OSM #1 was informed that observations made onsite on 4/29/2020 raised

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concerns. OSM #1 then asked to be informed of those concerns, and was informed of the findings of curtains not closed between positive and negative residents, of positive residents roaming freely without PPE and coming into close contact with negative residents. OSM #1 was informed of the facility staff member without PPE in direct contact with a COVID-19 positive resident, with subsequent direct contact with a COVID-19 negative resident. OSM #1 stated that the CEO had not told him these things, and that there seemed to be more to this story. OSM #1 stated, "Those things can be fixed."

From 5/1/2020 through 5/3/2020, a review of the facility presented several POC (plan of correction) drafts, which were reviewed and declined, due to not meeting all the requirements.

On 5/4/2020, the facility presented the following plan of correction.

"1. On 4/29/2020, Resident #1 was redirected to her room by staff when observed outside of her room. Resident refuses to leave facemask in place. On 4/29/2020, Resident #2 was redirected to her room by staff when observed outside of her room. Resident refuses to leave a facemask in place. On 4/29/2020, Resident #3 was redirected by staff when observed outside of her room. Resident refuses to leave facemask in place. All care plans reflect refusal to wear facemask.

On 4/29/2020, curtains were not pulled between resident beds in cohorted rooms, room # 220, 216, 210, 216, and 225. Rounds on 4/30/2020 showed privacy curtains pulled appropriately in room 220, 216, 210, 216, and 225

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F 880	Continued From page 21 On 4/29/2020, Nurse #1 observed having direct contact with two positive COVID 19 residents wearing only a facemask, no other PPE. Rounds on 4/30/2020 completed by VP [vice president] of Clinical Services showed all staff wearing appropriate PPE while interacting with residents. Any negative resident has potential to be at risk for contracting viral pathogens due to cohorting of positive and negative residents in the same areas within the facility 2. Room changes implemented to move residents to designated positive and negative areas within the facility. On North Unit, the unit will be divided into positive and negative zones, separated by a fire door. Two positive rooms will be outside the doors but will house non wandering residents that stay in their rooms. COVID positive Residents noted to wander will be housed behind the closed fire doors to prevent wandering into negative areas. South Unit will be divided by the hallway in front of the nurses' station with negatives and positives on either side of the unit. COVID positive Residents noted to wander will be housed behind the closed fire doors to prevent wandering into negative areas. Any positive rooms outside of fire door will house non wandering residents that stay in their rooms. Negatives with symptoms will be cohorted together. When optimal staffing present, Staff working with positive residents will only be assigned to the COVID zone with use of full PPE: One designated nurse on 7-3 and 3-11, and half of the scheduled CNA's. One nurse 7-3 and 3-11, one half of scheduled CNA's will be designated to the	F 880		

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negative zone. 11-7 has only one nurse per unit, so that nurse will provide medications and complete assessments to negative residents first, and then complete same tasks on the COVID unit wearing appropriate PPE, half of CNA's will be assigned to COVID positive zone. This applies to both North and South Unit. Medication carts will be designated to the positive and negative areas, and will remain in their designated area.

When staffing is less than optimal and staff must have assignments which include residents with both positive and negative test results, staff will attempt to provide care to negative residents first, using standard precautions and face mask. When leaving negative zone, must remove surgical facemask, and wash their hands. When entering positive zone, must don full PPE, including N95 mask prior to providing care to positive residents. Staff are educated to wash hands or use hand sanitizer before and after changing gloves, and to change gloves between residents, and to change isolation gowns between positive residents. If a staff member must go from positive to negative residents, they must dispose of PPE when leaving the positive zone, wash hands, apply a surgical facemask and then enter negative zone. When reentering positive zone, must dispose of surgical mask and apply N95, and full PPE.

Staff will follow CDC guidance on use of full PPE when interacting with positive residents.

All rooms, both positive and negative, are being terminally cleaned before a resident is taken into the room. Negative rooms are being cleaned first. Resident beds and nightstands are being moved with the resident. Rooms are cleaned with

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PHQ9 and a 1:10 bleach solution, including floors, bathrooms, sinks, closets, drawers, overbed tables, etc. All personal items are being wiped down with bleach solution or replaced. Room divider curtains are being removed and replaced. Housekeeping will continue to follow cleaning schedules, to be completed daily.

3. The VP (vice-president) of Clinical Services educated Nurse #1 on full PPE use with COVID positive residents on 4/30/2020.

The Director of Nursing will educate all nursing staff regarding appropriate use of full PPE when caring for COVID positive or negative residents based on staffing levels by 5/4/2020.

The Director of Nursing/Designee will review new admissions for identification of COVID status to ensure that resident is admitted to designated area in the facility on isolation for 14 days. Will be ongoing throughout duration of COVID 19 pandemic.

The Director of Nursing/ Designee will complete room rounds to ensure staff are wearing full PPE appropriately to prevent viral spread. Rounds will be completed 2x [times]/day for 4 weeks, then daily x 4 weeks, or until viral spread is resolved.

4. Results of audits will be brought to QAPI by the Director of Nursing x 2 months or until compliance is achieved. The members of the QAPI committee include the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS, Business Office Manager, Activities Department Manager, Admissions Coordinator, Social Services Director, Housekeeping Director, Maintenance Director,

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and Central Supply Coordinator.

Date of Compliance 5/4/2020"

On 5/4/2020 at 11:13 a.m., ASM #2, the director of nursing, was interviewed by phone. When asked about the initial decision to leave COVID-19 positive and COVID-19 negative residents in the same room, ASM #2 stated that when the first few positive test results came back, the facility staff tried to move residents to keep like-resulted residents together in the same room. However, when all the test results flooded in, and there were "so many" COVID-19 positive residents, in addition the large number of staff members who tested positive, the number of staff available to move residents was "dwindling." She stated that, based on conversations with the local health department and the local hospital system, the decision was made to leave all residents where they were. ASM #2 stated there was much discussion about the negative impact on residents that would result from so many moves. When asked why the facility's initial response was to place like-resulted residents together (positive with positive/negative with negative), ASM #2 stated, "Well, that is normal isolation practice." She went on to add that the COVID-19 virus is "new." When asked what resources the facility used to make decisions regarding resident placement during this outbreak, ASM #2 stated, "VDH (Virginia Department of Health) and CDC (Centers for Disease Control) guidelines." When asked what type of isolation precautions should be implemented for residents with COVID-19, ASM #2 stated, "Droplet." When asked about the surveyor's observation of ASM #2, coming directly in contact with Residents #3 and #13 without wearing gown or gloves, ASM #2 stated, "That

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was the first day of not wearing it. It was the first day." She stated she knew she should have been wearing a mask, gown, and gloves when coming into direct contact with residents. She stated she should have worn the mask, gown, and gloves, and should have "changed all of it" in between residents. She stated she should have sanitized her hands between removing the gloves after contact with one resident, putting on new gloves before contact with the next resident. When asked if she was implementing droplet precautions to prevent the spread of COVID-19, ASM #2 stated she was not. When asked if Resident #3 and Resident #13 should have been wearing a mask, ASM #2 stated, "Yes."

When asked whether a COVID-19 positive resident should be allowed within six feet of a COVID-negative resident, ASM #2 stated, "No." When asked if a COVID-19 positive resident who is moving around outside of their room should be wearing a mask, ASM #2, stated, "They have to wear a mask." When asked why wearing a mask was important, she you stated that the mask helps to prevent the possible spread of the virus. ASM #2 stated the COVID-19 negative resident would be at risk of contracting the virus. When asked if droplet precautions had been implemented for Resident #2 to prevent the spread of COVID-19 to Resident #5 in the encounter observed between them in the common area, ASM #2 stated the precautions had not been implemented. When asked if droplet precautions were implemented for Resident #2 and #13 to prevent the spread of COVID-19 to Resident #13, a COVID negative resident who was observed without a mask in place, during the encounter with Resident #2, who was COVID positive in the hallway, ASM #2

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stated the precautions had not been implemented.

On 5/4/2020 at 1:48 p.m., the facility's POC was accepted, and ASM #1 was informed of the acceptance. The facility presented credible evidence that the POC had been implemented, including evidence of room moves, and of employee education regarding staffing and PPE usage. The survey team remotely reviewed the credible evidence, and completed staff interviews by phone, verifying full implementation of the POC.

On 5/5/2020 at 2:00 p.m., the survey team entered the facility to perform the onsite portion of the POC validation. During the course of this onsite visit, the survey team made the following observation.

On 5/5/2020 at 3:24 p.m., the survey team entered the South Wing of the facility. At 3:31 p.m., the surveyor observed Resident #14 sitting in the common area behind the closed fire doors of the COVID-19 positive end of the unit. At 3:38 p.m., Resident #14 stood up and walked down the hall, through the fire doors, and up to the nurses' station. Resident #14 was not wearing a mask or any other PPE. The nurse station was located directly across from a room (218) where two COVID-19 negative residents were placed. The resident stood at the nurses' station for approximately five minutes asking for a cup of coffee. CNA (certified nursing assistant) #1, wearing gown, gloves, and mask, assisted the resident back through the fire doors and attempted to encourage the resident to return to his room. CNA #1 left the resident long enough to prepare a cup of coffee, which she delivered to

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the resident in his room. At 3:49 p.m., Resident #14 left his room, and walked into the common area. After walking to the window and looking outside, he sat down and began watching television. Resident #14 still was wearing no PPE. When the surveyors left the South Unit at 4:12 p.m., no efforts had been made by any staff member to disinfect the nurses' station area where Resident #14 had been standing.

On 5/5/2020 at 4:20 p.m., LPN (licensed practical nurse) #2, the South Unit manager, was asked to explain how residents were placed on the South Unit with regard to COVID-19 status. LPN #2 stated that most COVID-19 positive residents were placed behind the fire doors where the surveyor had observed Resident #14 walking around and sitting to watch television in the common area. LPN #2 stated that "a few" COVID-19 positive residents were placed beyond the fire doors, but those residents were not "wanderers." She stated COVID-19 positive residents who wandered were all placed behind the closed fire doors. She stated most all the COVID-19 negative residents on the South Unit were placed on the other side of the fire doors.

On 5/6/2020 at 11:22 a.m., after consultation with the Long Term Care supervisor, the survey team concluded that based on the observation the previous day of the COVID-19 positive resident without PPE or a mask wandering into the COVID-19 negative area to the nurses' station, the IJ (Immediate Jeopardy) was not abated.

On 5/6/2020 at 11:49 a.m., ASM (administrative staff member) #1, the acting administrator, was contacted by phone and notified that the IJ was not abated. ASM #1 was informed that during the

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onsite visit to verify the POC (plan of correction) that had been submitted, Resident #14's was observed wandering to the nurses' station, from the positive unit to the negative unit without a mask or PPE. ASM #1 was informed the POC to prevent the spread of a communicable illness, had not been fully implemented. ASM #1 was informed that per the facility's POC that the facility documented they would prevent the wandering of COVID-19 positive residents into areas where the residents would have the potential to exposed COVID-19 negative residents to the virus. ASM #1 stated, "I need to change that." The surveyor reminded ASM #1 that the focus of the IJ was on the facility's failure to implement an infection control program to prevent the spread of a communicable disease. ASM #1 stated, "By the time we get this done, they will all be off isolation."

On 5/6/2020 at 3:50 p.m., a phone interview was conducted with ASM #1. When asked specifically about Resident #14, and how the facility was implementing their infection control program to prevent the spread of COVID-19 with regard to Resident #14, ASM #1, the interim administrator stated, "We're moving [Resident #14] to the North Wing. This resident knows what he's doing he just wants coffee." ASM #1 stated Resident #14 was being assessed that day to determine if the resident was appropriate to have a private coffee carafe in his room. She stated the resident would be able to walk around most of the entire North Unit, would be able to get a cup of coffee or talk to the nurses, and would not get near rooms where COVID-19 negative residents were placed. The current POC just submitted by the facility was discussed with ASM #1, specifically the assumption that a staff member would always be

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available to intervene and to redirect wandering residents before they crossed between COVID-19 positive and negative areas. ASM #1 stated, "I can't guarantee every moment." At this time, the surveyor informed ASM #1 that the most recent POC submitted by the facility had been reviewed by the survey team and the Long Term Care supervisor, and had not been accepted.

On 5/6/2020 at 6:15 p.m., the facility submitted the following POC:

"1. On 5/5/2020, Resident #3 was noted to be at nurses' station asking for coffee without a mask, across from negative room. He was redirected to his room by staff with two cups of coffee provided. Resident with BIMS of 15 and is noted to visit the nurses station often to make requests for coffee. Resident #3 will be moved to North Unit into a private room in the positive zone which allows him more space to ambulate, and can ambulate to nurses station to make needs known. Resident will be evaluated by therapy to determine safety, then if deemed safe will be provided a carafe of coffee and a cup with a safety lid in his private room.

Any negative resident has potential to be at risk for contracting viral pathogens due to cohorting of positive and negative residents in the same areas within the facility, and by positive residents ambulating to negative zones.

2. Room changes will be implemented to make North wing the designated positive unit and South wing the designated negative unit. One staff member will be appointed to sit in the hallway between units 24 hours a day seven days a week to ensure that no resident ambulates off of their

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designated unit until viral spread is resolved. The staff member must be present at all times, and only take break when another staff member can relieve them. The designated staff member will have a walkie talkie to communicate with unit staff.

Staff will follow CDC guidance on use of full PPE when interacting with positive residents.

All rooms, both positive and negative, are being terminally cleaned before a resident is taken into the room. Negative rooms are being cleaned first. After being cleaned, Resident beds and nightstands are being moved with the resident. Rooms are cleaned with PHQ9 and a 1:10 bleach solution, including floors, bathrooms, sinks, closets, drawers, overbed tables, etc. All personal items are being wiped down with bleach solution or replaced. Room divider curtains are being removed and replaced. Housekeeping will continue to follow cleaning schedules, to be completed daily, to include nurses stations and areas that positive residents may come in contact with. Medication carts on South Unit will be stored in the clean utility room when not in use and will be cleaned with bleach wipes prior to each med pass. Residents will have a facemask placed prior to the room moves while in the hallways.

3. The Director of Nursing/Designee will educate all staff on the room moves to ensure that positive residents are moved and reside on North Wing and that negative residents reside on South wing by 5/7/2020.

The Director of Nursing/Designee will review new admissions for identification of COVID status. If COVID positive, will be placed on the positive

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unit. If negative or status unknown, new admissions will be placed in a private room with isolation precautions x 14 days. The Director of Nursing will educate the admissions nurse on admission requirements by 5/7/2020.

The Director of Nursing/ Designee will complete room rounds to ensure staff are wearing full PPE appropriately to prevent viral spread. Rounds will be completed 2x/day for 4 weeks, then daily x 4 weeks, or until viral spread is resolved.

4. Results of audits will be brought to QAPI by the Director of Nursing x 2 months or until compliance is achieved. The members of the QAPI committee include the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS, Business Office Manager, Activities Department Manager, Admissions Coordinator, Social Services Director, Housekeeping Director, Maintenance Director, Central Supply Coordinator, Human Resources Director, Dietary Manager, and Certified Nursing Assistant.

Date of Compliance 5/7/2020"

On 5/6/2020 at 6:15 p.m., ASM #1 was notified that the POC was accepted.

On 5/8/2020, the facility submitted credible evidence that the POC had been fully implemented. The survey team reviewed the credible evidence remotely and completed interviews with staff by phone to verify implementation of the POC.

On 5/8/2020 at 12:00 p.m., the survey team entered the facility to make observations to verify

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that POC had been fully implemented. These observations revealed no concerns with the facility's implementation of an infection control program to prevent the spread of communicable disease, COVID-19.

On 5/8/2020 at 1:18 p.m., ASM #1 was notified that the IJ was abated.

References:

(1) "Coronaviruses are a large family of viruses found in many different species of animals, including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the outbreak of respiratory illness in people first detected in Wuhan, China, has been named SARSCoV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by SARS-CoV-2 has been named COVID-19. This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments

(2) "PPE: Personal protective equipment is special equipment you wear to create a barrier between you and germs. This barrier reduces the chance of touching, being exposed to, and spreading germs." This information was obtained from the website:https://medlineplus.gov/ency/patientinstructions/000447.htm

(3) "In males, the perineum lies just below the pelvic floor muscles, which support the bladder and bowel. The perineum protects the pelvic floor muscles and the blood vessels that supply the genitals and urinary tract." This information is taken from the website

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https://www.niddk.nih.gov/health-information/urologic-diseases/perineal-injury-males.

(4) "COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

(5) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.

(6) Use Droplet Precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking ...Source control: put a mask on the patient. Ensure appropriate patient placement in a single room if possible. In acute care hospitals, if single rooms are not available, utilize the recommendations for alternative patient placement considerations in the Guideline for Isolation Precautions. In long-term care and other residential settings, make decisions regarding patient placement on a case-by-case basis considering infection risks to other patients in the room and available alternatives. In ambulatory settings, place patients who require Droplet Precautions in an exam room or cubicle as soon as possible and instruct patients to follow Respiratory Hygiene/Cough Etiquette recommendations. Use personal protective equipment (PPE) appropriately. Don mask upon entry into the patient room or patient space. Limit

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transport and movement of patients outside of the room to medically-necessary purposes. If transport or movement outside of the room is necessary, instruct patient to wear a mask and follow Respiratory Hygiene/Cough Etiquette." This information is taken from the website https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html.

(7) "Alzheimer's disease is an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks. It is the most common cause of dementia in older adults." This information is taken from the website https://www.nia.nih.gov/health/alzheimers/basics.

(8) "Psychotic disorders are severe mental disorders that cause abnormal thinking and perceptions. People with psychoses lose touch with reality." This information is taken from the website https://medlineplus.gov/psychoticdisorders.html.

(9) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(10) "Schizoaffective disorder is a mental condition that causes both a loss of contact with reality (psychosis) and mood problems (depression or mania)." This information is taken from the website https://medlineplus.gov/ency/article/000930.htm.

(11) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain

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chemical called dopamine." This information is taken from the website https://medlineplus.gov/parkinsonsdisease.html.

Information for infection control and COVID in long-term care facilities obtained from the CDC website https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#adhere

2. Resident #15 was admitted to the facility on 10/23/15; diagnoses include, but are not limited to, epilepsy (1) and Pick's disease (2). On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 3/14/2020, Resident #15 was coded as being severely impaired for making daily decisions, having scored zero out of 15 on the BIMS (brief interview for mental status). He was coded as having both arm and leg contractures (3) on both the right and left sides. Resident #15 was coded on being completely dependent on the extensive assistance of staff for toileting. He was coded as always being incontinent of both bladder and bowel.

On 4/29/2020 at 2:01 p.m., CNA (certified nursing assistant) #2 and CNA #3 entered Resident #15's room to provide incontinence care to Resident #15. Both CNAs were wearing gown, gloves, and mask. CNA #2 cleaned Resident #15's buttocks and perineal area (4) of urine and stool. CNA #2 threw away the wipes she had used, and removed the incontinence brief from underneath

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Resident #15. Without changing gloves or sanitizing her hands, CNA #2 obtained a clean incontinence brief, and, with the help of CNA #3, secured the brief on the resident. CNA #2 continued her care for Resident #15, including helping to move the resident up in bed, and wiping the resident's face with a wipe. She provided this additional care without changing her gloves or sanitizing her hands. When CNA #2 had completed all care for Resident #15, she removed her gloves and gown, and washed her hands.

On 5/4/2020 at 11:13 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked about the process staff should follow after cleansing a resident's buttocks and perineal area of urine and stool, ASM #2 stated the staff members should wash hands and put on clean gloves. ASM #2 was asked if it was acceptable for a staff to wipe a resident's face wearing gloves worn during insentience care. ASM #2 stated, "Absolutely not."

On 5/4/2020 at 11:31 a.m., CNA #4 was interviewed. When asked about the process staff follows during incontinence care after cleansing a resident's buttocks and perineal area of urine and stool, CAN #4 stated, "You take off your gloves. Then you wash your hands. Then you put on clean gloves." When asked why it is important to wash hands and change gloves between dirty and clean tasks, CNA #4 stated, "To prevent cross contamination." She stated there was a risk of causing infection or skin breakdown if gloves were not changed.

On 4/29/2020 at 4:02 p.m., ASM #1, the acting administrator, was informed of these concerns.

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A review of the facility policy "Handwashing" revealed, in part: "Purpose: The purpose of this procedure is to provide guidelines to employees for proper and appropriate handwashing techniques that will aid in the prevention of the transmission of infection...Appropriate...handwashing must be performed under the following conditions...After contact with blood, bodily fluids, secretions, excretions, mucous membranes, or broken skin."

No further information was provided prior to exit.

REFERENCES

(1) "The epilepsies are a spectrum of brain disorders ranging from severe, life-threatening and disabling, to ones that are much more benign." This information is taken from the website https://www.ninds.nih.gov/Disorders/All-Disorders/Epilepsy-Information-Page.

(2) "Pick's disease is a neurological condition characterized by a slowly progressive deterioration of behavior, personality, or language." This information is taken from the website https://rarediseases.info.nih.gov/diseases/7392/behavioral-variant-of-frontotemporal-dementia

(3) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm.

(4) "In males, the perineum lies just below the

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	495255	A. BUILDING _____ B. WING _____	05/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 880	Continued From page 38 pelvic floor muscles, which support the bladder and bowel. The perineum protects the pelvic floor muscles and the blood vessels that supply the genitals and urinary tract." This information is taken from the website https://www.niddk.nih.gov/health-information/urologic-diseases/perineal-injury-males.	F 880		