STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495155	A. BUILDING _____ B. WING _____	01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE HEALTHCARE CENTER	6700 COLUMBIA PIKE ANNANDALE, VA 22003

(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 1/13/2021 through 1/14/2021. The facility was in compliance with E0024 of 42 CFR part 483.73, Requirements for Long-Term Care Facilities.	E 000	Annandale Healthcare Center is filling this document for the purposes of regulatory compliance. The submission of the plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiency.	
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control survey was conducted 1/13/2021 through 1/14/2021. 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. The census in this 222 certified bed facility was 139 at the time of survey. 100 residents had tested positive for COVID-19. 62 staff had tested positive. 55 residents had recovered from COVID-19. At the time of the surcey there were no positive staff or residents in the facility.	F 000	RECEIVED JAN 29 2021 VDH/OLC	
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility 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—	F 885	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #7 was discharged from facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current residents were audited to ensure that they were notified about the current	

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

Amadora, LNHA 1/28/2021

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 885	Continued From page 1 (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 interview, staff interviews, and clinical record review, the facility's staff failed to inform a resident residing in the facility and/or their representative and family of confirmed infection of COVID-19, identified on 12/17/20, 12/24/20 and 12/30/20 for 1 of 10 residents (Residents #7), in the survey sample. The findings included; Resident #7 was originally admitted to the facility 2/16/19 and readmitted 10/16/20 after an acute care hospital stay. The current diagnoses included: chronic pain, spinal stenosis, and liver cirrhosis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/16/19 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.	F 885	cases of positive Covid-19. All current residents were notified through hand-delivered letter. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? An in-service will be done to licensed nurses (RN's, LPN's), and social workers regarding the notification of Covid-19 positive cases in the facility. The in-service will be done by the staff development nurse. A letter will be issued to all residents regarding the current positive Covid-19 cases by 5PM the next calendar day. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The administrator will audit 20% of medical records to ensure that residents were notified regarding the positive Covid-19 cases in the facility. The audit will be done every time there's a positive Covid-19 case for a period of three (3) months. Results of the audit will be submitted to the QAPI committee for the three (3) month period. At the end of the three (3) month period, the QAPI committee will determine if additional interventions are needed. Date of Compliance: February 8, 2021	

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F 885	Continued From page 2 Review of facility's documentation revealed there were five confirmed cases of staff infection of COVID-19 on 12/17/20, one confirmed case of staff infection of COVID-19 on 12/24/20, and another five confirmed cases of staff infection of COVID-19, on 12/30/20. An interview was conducted with Resident #7, on 1/13/21 at approximately 12:10 p.m. Resident #7 stated during a resident meeting a few weeks ago they were told by the administrative staff that the facility would be more transparent with the residents regarding the COVID-19 pandemic events occurring within the facility, yet he has never had a staff member inform him of results of the many COVID-19 test they had performed on him. Therefore, he assumes they are negative because he was not asked to move to the special unit. Resident #7 stated the administrative staff informed them during the meeting there was a special unit for COVID-19 positive residents to reside as they recovered from the virus. Resident #7 also stated he had never been informed of confirmed infection of COVID-19 positive cases involving staff or residents within the facility. The resident further stated his son was young and he didn't want him involved with facility information or his health status therefore, all information should have been provided to him, as he is his own responsible party. Review of Resident #7's clinical record (after employees confirmed cases of COVID-19 were identified on 12/17/20, 12/24/20 and 12/30/20) revealed no documentation that Resident #7 was informed of the new COVID-19 occurrences identified. The call system provided by the facility's staff of	F 885		

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F 885	Continued From page 3 all calls to inform residents, their representatives, and families of those residing in facilities of confirmed infection of COVID-19 or new-onset of respiratory symptoms occurring within 72 hours of each other, was reviewed. Resident #7's name was not observed and neither was any person representing the resident. On 12/18/20 at approximately 3:28 p.m., the above findings were shared with the Administrator and the Assistant Director of Nursing. The Administrator stated they had no additional information to present.	F 885		