STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING _____ B. WING _____	12/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(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 on 12/15/20 and continued with offsite review 12/16/20 through 12/18/20. 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 12/15/20 and continued with offsite review 12/16/20 through 12/18/20. 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 180 certified bed facility was 134 at the time of survey. Nineteen residents had tested positive for COVID-19, one resident had died, two were in the hospital, three residents remained in the facility with COVID and thirteen had recovered. Twenty-one employees had tested positive for COVID-19 and fifteen had recovered.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		1/14/21

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

Electronically Signed | 01/14/2021

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 880	Continued From page 1 §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 must prohibit employees with a communicable	F 880		

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F 880	Continued From page 2 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, staff interviews and facility documentation, the facility staff failed to ensure infection control measures were consistently implemented to prevent the development and/or transmission of a communicable disease (COVID-19), and other infectious diseases for 1 of 3 residents in the survey sample (Resident #1). The facility staff failed to ensure one resident maintained social distancing and wore a face covering for source control when leaving his room. The findings included: Resident #1 was originally admitted to the facility on 12/27/16 and re-admitted on 08/07/20. Resident #1's diagnoses included Chronic Respiratory Failure and Unspecified Asthma.	F 880	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F880 1. Resident #1 has been re-educated on the importance of being compliant with the	

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F 880	Continued From page 3 The most recent Minimum Data Set (MDS) a Quarterly Revision with an assessment reference date (ARD) of 11/18/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) scoring a 15. This coded Resident #1 as being cognitively intact. In section "G" (Physical functioning) the resident was coded as Independent with bed mobility, transfers, locomotion on the unit, dressing, eating, toileting and personal hygiene. On 12/15/20 at approximately 12:25 p.m.., an observation was made during the initial tour on Unit 1. Resident #1 was observed standing beside the medication cart, less than 6 feet away, talking to Licensed Practical Nurse (LPN #1) without wearing a face covering. No redirection was given by the nurse. The DON (Director of Nursing) was also nearby in the hallway. Shortly thereafter, Resident #1 was seen ambulating down the hallway entering his room. A brief interview was conducted on 12/15/20 at 12:30 p.m. with LPN #1 concerning the resident not wearing a face covering. She stated, "I didn't notice that he wasn't wearing a mask." On 12/17/20 at 1:30 p.m. a telephone interview was conducted with the Infection Control Nurse Registered Nurse (RN #1) concerning Resident #1 not wearing a face covering. She stated, "We provide cloth face mask. For non compliant residents we do remind them to put their mask back on or ask them to get their mask out of the room. Resident's wear cloth masks unless they have an appointment, then they wear a surgical mask. Resident #1 is alert and oriented times four. He's very aware of our policy and	F 880	use of a facial covering when he exits his room. A visual cue has been placed on his door per his request and his care plan has been revised. LPN #1 was re-educated on reminding and redirecting residents who exit their room without a face covering. 2. Residents are monitored for use of a face covering and facial distancing per CDC guidelines. 3. Nursing staff were educated on reminding and redirecting residents to use a face covering and to maintain social distancing when out of their room. 4. A Nurse will complete a random daily review to ensure that Nursing staff provide redirection for use of face covering and/or social distancing by residents. 5. Results of the review will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: January 14, 2021	

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F 880	Continued From page 4 procedure." RN #1 stated "The nurse should have reminded him to go get his mask." A review of Resident #1's Care Plan read as follows: Focus-The Resident is non-compliant with wearing a mask and/or keeping mask on while in hallways of the facility. Created and Revised on 06/12/20. Goal: The resident will cooperate with wearing of mask as much as possible thru the next review. Created on 6/12/20. Revision on 8/19/20. Target Date 3/01/2021. Interventions: Encourage/remind resident to wear or replace mask as needed; Give clear explanation of reason for need to wear mask when out of room as needed; If resident resists or refuses to wear mask, explain reason and attempt to replace mask or return to room as needed. On 12/18/20 at 3:45 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate staff. No comments were voiced.	F 880		
F 886 SS=D	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 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:	F 886		1/14/21

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F 886	Continued From page 5 (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 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	F 886		

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F 886	Continued From page 6 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 resident interviews, staff interviews, and clinical record review, the facility staff failed to inform one resident (Resident #2), of 3 residents in the survey sample, of their COVID-19 laboratory results. The findings included: Resident #2 was originally admitted to the facility 5/19/17 and readmitted on 10/04/17. The current diagnoses included; Chronic Atrial Fibrillation and Type 2 Diabetes Mellitus The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 09/02/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were intact. An interview was conducted with Resident #2 on 12/15/20 at approximately 12:48 p.m. during the initial tour of the facility. Resident #2 was ask if he was being informed of his COVID-19 results. He stated, "They don't tell you results. They check us on Monday or Tuesday. I figure that as long as I don't hear from anyone, I'm okay."	F 886	F886 1. Resident #2 is aware of his Covid-19 results. Testing, results, and notification are documented in the medical record. 2. Residents were reviewed to ensure that documentation of notification of Covid-19 results are present in the medical record. 3. Nursing staff were educated on notifying the resident/responsible party of Covid-19 testing and results and documenting the testing, results, and notification in the resident□s medical record. 4. A nurse will monitor the notification and documentation on a weekly basis. 5. Results of the monitoring will be presented to the Quality Assurance Committee for review and recommendation. 6. Completion date: January 14, 2021	

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F 886	Continued From page 7 On 12/17/20 at 1:50 p.m. an interview was conducted with the DON (Director of Nursing) concerning Resident#2 not being informed of his COVID-19 results. She stated, "We don't notify family if resident is negative; we don't document if results are negative." The DON stated "If we come back to you (the Resident) your results are positive." The COVID-19 timeline revealed staff and resident testing. The recent results from 10/01/20 until 12/15/20 revealed the following: 12/01/20- All staff negative, One Patient community acquired was positive. 12/03/20- one Staff positive and one resident positive. 12/04/20 - two positive residents, 12/08/20 two positive staff. 12/09/20 two positive residents, 12/10/20 four positive staff. A review of the resident's clinical records revealed COVID-19 test results were not documented in the resident's progress notes, nor were notifications informing Resident #2's RP (Responsible Party) of COVID-19 test results documented. On 12/18/20 at 3:45 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate staff. No comments were voiced at this time.	F 886		