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COLONIAL HEALTH & REHAB CENTER, LLC	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite 12/8/20 and continued offsite from 12/9/20 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 12/8/20 and continued with offsite review from 12/9/20 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. Two complaints were investigated during the survey. The census in this 90 certified bed facility was 62 at the time of survey. Four residents had tested positive for COVID-19. Three of those residents currently remained COVID-19 positive at the time of the survey. One employee who tested positive for COVID-19 no longer worked at the nursing facility.	F 000		
F 880 SS=E	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	Education was provided to staff on assisting Residents with the use of procedure masks when less than 6 feet apart during all care tasks, on reporting to nursing staff of any Resident refusals to wear procedure masks during care tasks, proper use of the PPE N95 mask. Family member and staff were educated on procedure for window visitation. All Residents are at risk when proper infection control practices are not followed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: K Spell | TITLE: Administrator | (X6) DATE: 1/1/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1 §483.80(a) 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 disease or infected skin lesions from direct	F 880	All staff have been educated on providing procedure masks for Residents during all care tasks, reporting to nursing staff Residents that choose not to wear during care tasks, proper usage of PPE and window visitation procedure. Department Heads and/or designee will conduct weekly staff and Resident audits of proper PPE usage X 4 weeks. Recreational Therapy and Social Serivces will conduct weely audits of window visitation to ensure proper procedure are met during window visitation X4 weeks. Infection Control Audits will be reviewed during monthly QAPI Meetings. Adjustments to content of audits and/or duration of monitoring will be made as deemed necessary.	1/8/2021

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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 review, the facility staff failed to ensure infection control standards were followed to prevent the transmission of COVID-19 infection. The facility staff failed to appropriately use Personal Protective Equipment (PPE), isolation gowns, facemask (N95 and procedural mask) for staff and residents during care and during therapies on the quarantine unit for 4 of 8 residents (Residents #1, #2, #3 and #4) in the survey sample. And, the facility failed to ensure visitation was conducted in a manner to prevent the spread of infection for 1 of 8 residents (Resident #5).

The findings included:

1. On 12/8/20 from approximately 1:00 p.m. to 2:00 p.m., the Occupational Therapist (OT) failed to offer Resident #1 a procedural face mask

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during the OT therapy session, which required less than 6 feet physical distance, to prevent the potential transmission of COVID-19 to self and other residents.

Resident #1 was admitted on 12/2/20 with diagnoses that included metabolic encephalopathy and weakness. The Admission Minimum Data Set (MDS) assessment dated 12/5/20 coded the resident with a score of 00 out of a possible score of 15 on the Brief Interview for Mental Status BIMS) which indicated she was severely impaired in the cognitive skills for daily decision making.

The care plan dated 12/6/20 identified that all facility staff would follow standard precautions and implement transmission based precautions as needed based on COVID-19 outbreak and the risk for infection r/t (related to) potential virus exposure and resident's current health status.

On 12/8/20 at approximately 3:25 p.m., during an interview with the OT and the Administrator, she stated she saw the resident's yellow procedural face mask in her room, but felt she was not in direct contact with the residents and was greater than 6 feet during the therapy session. She also stated she had been inserviced to ask residents to apply a facemask during therapy and would remember to do so with future therapy sessions.

On 12/8/20 at approximately 4:00 p.m., the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) joined the interview with the Administrator. Both the DON and the RDCS stated they expected the staff to offer the residents a procedural mask during direct nursing care, as well as during therapy in

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their rooms and that the resident would also wear one when they are out of their rooms.

2. On 12/8/20 from approximately 2:09 p.m. to 2:41 p.m., the Occupational Therapist (OT) failed to offer Resident #2 a procedural face mask during the OT therapy session, which required less than 6 feet physical distance, to prevent the potential transmission of COVID-19 to self and other residents.

Resident #2 was admitted on 11/30/20 with diagnoses that included seizures and generalized weakness.

The Admission Minimum Data Set (MDS) dated 12/1/20 coded the resident with short and long term memory problems and moderately impaired in the cognitive skills of daily life.

The care plan dated 12/9/20 identified that all facility staff would follow standard precautions and implement transmission based precautions as needed based on COVID-19 outbreak and the risk for infection r/t potential virus exposure and resident's current health status.

On 12/8/20 approximately 3:25 p.m., during an interview with the OT and the Administrator, the OT stated she saw the resident's yellow procedural face mask in her room, but felt she was not in direct contact with the residents and was greater than 6 feet during the therapy session. She also stated she had been inserviced to ask residents to apply a facemask during therapy and would remember to do so with future therapy sessions.

On 12/8/20 at approximately 4:00 p.m., the

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Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) joined the interview with the Administrator. Both the DON and the RDCS stated they expected the staff to offer the residents a procedural mask during direct nursing care, as well as during therapy in their rooms and that the resident would also wear one when they are out of their rooms.

3. On 12/8/20 from approximately 1:34 p.m. to 2:18 p.m., the Physical Therapy Assistant (PTA) failed to offer Resident #4 a procedural face mask during the PT therapy session, which required less than 6 feet physical distance, to prevent the potential transmission of COVID-19 to self and other residents.

Resident #4 was admitted on 11/17/20 with diagnoses that included cellulitis of left lower limb and generalized weakness.

The Admission Minimum Data Set (MDS) assessment dated 11/23/20 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status BIMS) which indicated he was cognitively intact in the skills for daily decision making.

The care plan dated 11/21/20 identified that all facility staff would follow standard precautions and implement transmission based precautions as needed based on COVID-19 outbreak and the risk for infection r/t potential virus exposure and resident's current health status.

On 12/8/20 approximately 3:25 p.m., during an interview with the PTA and the Administrator, the PTA said there was a procedural mask in Resident #3's room, but stated he did not offer

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the resident a yellow procedural face, because most of the time he refused to wear one. He stated, "I could be more forceful when they refuse to wear a mask." It was discussed that a resident should not be forced to wear a facemask, but refusals should be reported to the nursing staff and physician.

On 12/8/20 at approximately 4:00 p.m., the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) joined the interview with the Administrator. Both the DON and the RDCS stated they expected the staff to offer the residents a procedural mask during direct nursing care, as well as during therapy in their rooms and that the resident would also wear one when they are out of their rooms.

4. The facility staff failed to adhere to infection control transmission-based precautions and the quarantine unit's requirement to wear full PPE when in Resident #4's room.

Resident #4 was admitted on 6/25/20 with diagnoses that included right femur closed fracture and heart failure.

The resident's most recent Minimum Data Set (MDS) was a significant change in status assessment dated 9/25/20. The MDS coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status BIMS) which indicated he was cognitively intact in the skills for daily decision making.

The care plan dated 11/17/20 identified that all facility staff would follow standard precautions and implement transmission based precautions as needed based on COVID-19 outbreak and the

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F 880	Continued From page 7 risk for infection r/t potential virus exposure and resident's current health status. On 12/8/20 at 1:40 p.m., Licensed Practical Nurse (LPN) #1 was observed coming out of Resident #4's room not wearing a disposal gown. She had on an N95 facemask and a faceshield. A second observation at 1:45 p.m. was made as this surveyor approached the medication cart in the hallway in front of the resident's room. LPN #1 had a medicine cup in her hand, still donned with the N95 facemask and faceshield, half way entered the resident's room, turned came out of the room, retrieved a disposable gown from one of the three compartment Sterilyte drawers, donned it and proceeded back into Resident #4's room. While in the room, a second LPN #2 walked into the resident's room without donning a disposable gown to have a conversation with LPN #1. When they both exited the resident's room, LPN #1 stated, "This is not my main job really, I am a traveling nurse." She proceeded to continue passing other resident medications. When LPN #2 was asked what offered protection when he was in Resident #4's room, he unzipped and took off his uniform jacket and stated, "My jacket offers protection." Upon further discussion about the PPE required on the quarantine unit, he said, "I should have gowned up before I went in his room and I did not, I just wanted to ask the nurse if another resident could have medication for anxiety. I could have waited until she came out, I'm guilty." On 12/8/20 at approximately 4:00 p.m., an interview was conducted with the Director of Nursing (DON), the Regional Director of Clinical Services (RDCS) and the Administrator. Both the DON and the RDCS stated they expected the	F 880		

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staff to don full PPE when entering any room on the quarantine unit.

On 12/10/20 at 2:50 p.m., telephone interview was conducted with the quarantine Registered Nurse (RN) unit manager/supervisor. She stated, "It is not an expectation, but a rule that full PPE is to be used by all that enter a resident room on the yellow unit (quarantine). It is the unit where we observe those for any presenting signs and symptoms of COVID-19 and you cannot bring in or out of those rooms any potential infection."

The facility's policy and procedures titled "Recommended use of personal protective equipment (PPE) for health care setting" dated 2/27/20 indicated that the quarantine unit (yellow unit) guidance included wearing full PPE for healthcare workers or anyone crossing the threshold into a patient room that is under suspicion/observation (new admissions). The PPE used on the unit included N95-Respirator, gown, gloves and eye protection.

5. On 12/8/20 at 12:30 p.m., during observation of staff in the therapy department, the Rehabilitation Director's N95-Respirator did not fit snug on her face, instead it had a large gap across the top of her nose and chin. The Rehab Director said, "I know, I try to pinch it close to my nose, but it does not fit." She stated she was fit tested by the previous owners, but not since they took over new ownership.

On 12/8/20 at 12:45 p.m., a second therapist (speech) entered the department and was also seen providing therapy to residents on the quarantine unit with a procedural mask under her N95-Respirator. She stated, "I feel it is safer to

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wear the procedural facemask under my N95 and it won't pinch my face. I have worn it this way all the time. No one has told me otherwise."

On 12/8/20 from 1:00 p.m. to 2:41 p.m., the Occupational Therapist (OT) providing therapy to residents on the quarantine unit was also observed to wear a procedural mask under her N95. The OT said, she always wore the procedural mask under her N95. She said she had post nasal drip if she did not wear the procedural mask, her mask would get wet, but stated everyone had three N95's to alternate on the COVID-19 positive unit and the quarantine unit, and the KN95's to wear on the COVID-19 free units. She continued to say she had been to the Ear Nose and Throat (ENT) doctor for the problem, but did not get a doctor's note to exempt her from wearing an N95.

On 12/8/20 at 4:00 p.m., an end of the day debriefing was held with the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services. They stated procedural facemask's were not to be worn under the N95 because the greater protection should be next to the face especially on the quarantine and COVID-19 positive units. They stated, if desired a procedural facemask can be worn over top of the N95. They were not aware that the aforementioned therapy department staff were inappropriately wearing their N95 and they did not have a doctor's note from the OT based on her voiced ENT problems. They were not aware that the Rehab Director's N95 was ill-fitted.

On 12/10/20 at 2:50 p.m., a telephone interview was conducted with the quarantine Registered Nurse (RN) unit manager/supervisor. She stated

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F 880	Continued From page 10 she was one of the nurse educators and also able to fit test any worker who is required to use a tight-fitting N95 respirator. She stated after it was brought to her attention on 12/9/20 from the DON and Administrator that several therapist were inappropriately wearing N95, she evaluated and fit tested each one. The RN unit manager stated the Rehab Director was wearing the wrong size N95 and re-issued her a small N95. She added that the speech therapist was re-educated on how to apply and check the seal with her face without a procedural facemask. She stated, the OT did not share any ENT issues or that she needed a doctor's note for an alternative facemask, thus she re-educated her also on how to apply and check the seal with her face. 6. Resident #5 was admitted to the nursing facility on 12/4/20 with diagnoses that included metabolic encephalopathy and multiple sclerosis. The Admission Minimum Data Set Assessment (MDS) dated 12/10/20 coded the resident with a score of 10 out of a possible score of 15 which indicated the resident was moderately impaired in the skills needed for daily decision making. The resident was assessed to have fluctuating disorganized thinking, hallucinations and delusions at the time of the assessment. The resident was coded to walk in her room with setup from one staff and supervision, and uses walker and wheelchair for mobility. On 12/8/20 at 2:42 p.m., a visitor was observed leaning half way through Resident #5's fully raised window. The visitor's facemask was positioned on his chin with his nose and mouth exposed. The resident's procedural facemask was hanging on her right ear with her nose and	F 880		

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mouth also exposed. As this surveyor passed the window, the visitor turned and it was asked of him, what he was doing and he responded, "I am visiting my Mom." A further question was asked if this was how he visited the resident, to which he responded, "Yes, this is how I visit her and what do you want to make of it." The front desk receptionist appeared outside, eyed the visitor at the window and immediately went inside to retrieve the facility's Administrator. The Administrator said he told the visitor that the window had to be closed during window visits.

On 12/8/20 at 3:00 p.m., the receptionist stated she periodically goes out the front of the building for air due to having to wear a facemask continuously in a closed space. She said, "As was coming through the front lobby, I could see (this surveyor's name) gesturing and speaking to someone and as I looked to the left, it became obvious that a male figure was leaning into a resident's window. I went to immediately tell the administrator." She stated that window visits are not scheduled, but most of the time a visitor will call and she or another staff person would make sure the resident was presentable and that the curtains and blinds were opened so the visitor could see the resident. She also stated, it was a team effort and someone would ensure either the in room phone was working or the resident's cell phone was accessible. She said video visits were set up by the activity's department.

On 12/8/20 at 3:30 p.m., the Administrator and this surveyor proceeded to Resident #5's room. While standing in the hallway, it was clearly visible that the window screen had been removed as it was leaning against the wall. According to the Administrator he was not aware of any visitor

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leaning in windows of residents during window visits and that the resident was probably capable of unlocking the window. The Administrator said he told the male visitor, who was the resident's son, that open windows were not allowed and the facility was not accepting outdoor or indoor visitations except for end of life situations.

On 12/10/20 at 2:04 p.m., a telephone interview was conducted with the Admission's Coordinator. She stated she saw a young man at Resident #5's (resident's son) window before 12:00 p.m. on 12/8/20 and approached him asking that he sign admission paperwork for consent to treat and discovered he was not the primary son she had spoken to earlier. She stated a call was made by the son at the window to the primary son the Admission Coordinator spoke to earlier who gave permission for the son visiting at the window to sign the necessary admission paper work. The Admission's Coordinator said she reminded the son at the window that the window could not be opened for visits with his mother because he would expose her potentially to the COVID-19 virus and that the son told her, "I understand, but I know how to keep my Mom calm." It was then told to the Admission's Coordinator that an incident on 12/8/20 revealed that the same son she informed not to open the window during his visits was caught hanging in the window on 12/8/20 at 2:42 p.m. She responded that when she spoke with the son on 12/8/20 around 12:00 p.m., the window was not open and they both were communicating via cell phones, but could not explain why she reminded him that the window could not be opened during his visits and his statement about calming his mother. The Admission's Coordinator said, "I really don't know why he said that, it was strange and he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. BUILDING _____ B. WING _____	C 12/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEALTH & REHAB CENTER, LLC	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

(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 13 pacing the entire time we were talking." The nurse's notes dated 12/9/20 at 6:56 a.m. indicated a call was made to the primary son on 12/8/20 to discuss the most recent issue with the open window to discuss COVID-19 protocol and window visitations. The note indicated that it was explained that windows could not be opened during visits and he responded he was aware and that his brother knew better. The note also indicated it was explained the importance of wearing facemask.	F 880		