STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	612 HOUSTON STREET STAUNTON, VA 24401

(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 06/08/2020 through 06/09/2020 and 06/17/2020. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000	1.CNA #1 was immediately re-educated on Hand Hygiene and completed both Hand Hygiene and Donning and Doffing PPE competencies on 6/17/2020. CNA #2 was immediately re-educated on Hand Hygiene and completed both Hand Hygiene and Donning and Doffing PPE competencies on 6/17/2020. A	(7/21/2020)
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted 06/08/2020 through 06/09/2020 and 06/17/2020. Corrections are required for the facility to be in compliance with 42 CFR Part 483.80 infection control regulations, and the CMS and Centers for Disease Control (CDC) recommended practices to prepare for COVID-19. On 05/05/2020 the census in this 170 certified bed facility was 156. There were no reported cases of COVID-19 in the facility. The facility reported they had tested four residents with negative results. On 06/17/2020 the census was 154. There were no reported cases of COVID-19 in the facility. The facility reported they had tested a total of 11 residents and 10 employees, all with negative results. No other staff or residents had been tested at the time of the survey.	F 000	Root Cause Analysis (RCA) conducted with a review of the facility's most current COVD-19 Pandemic Plan by Quality Assurance and Performance Improvement (QAPI) committee. 2.DON/ designee will conduct Hand Hygiene and Donning and Doffing PPE competencies with facility staff, specifically using hand sanitizer before glove use. 3.DON/ designee will re-educate facility staff on Handwashing/ Hand Hygiene Policy and Procedure and perform Hand Hygiene and Donning and Doffing PPE competencies 4.DON/ designee will conduct random observations of staff to ensure they are washing their hands and appropriate times. DON/ designee will perform 10 random Hand Hygiene and Donning and Doffing PPE competencies weekly for a period of 8 weeks. Findings will be reported to the QAPI committee.	
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	F 880	5.Allegation of Compliance (7/21/2020) RECEIVED JUL 08 2020 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Celia Pope | TITLE: Interim Executive Director | (X6) DATE: 7/7/202

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	612 HOUSTON STREET STAUNTON, VA 24401

(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 1 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24401

(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 2 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure hand hygiene was performed while delivering meal trays, and also failed to properly doff (remove) gloves on one of 5 units: 2 New South. Staff delivering meal trays did not perform hand hygiene prior to and upon exiting resident rooms. Staff also failed to perform hand hygiene after removing gloves prior to applying clean gloves. Findings include: On 6/17/20 at approximately 12:15 p.m., staff were observed delivering lunch trays. CNA (certified nursing assistant) # 1 took the meal tray into a resident room without performing hand hygiene. CNA # 1 proceeded to set the tray on	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496243	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	612 HOUSTON STREET STAUNTON, VA 24401

(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 3 the overbed table, adjust the table and leave the room without performing hand hygiene. CNA # 1 then delivered a meal tray to another resident room, did not perform hand hygiene, then transferred a walker twice without performing hand hygiene before leaving the room. CNA # 1 was asked about the observation and she stated "Yes, I did." CNA # 1 was advised there had been no observation of hand hygiene. At approximately 12:35 p.m. CNA # 2 was observed delivering meal trays to the room designated as the quarantine room for new admissions. CNA # 2 was observed removing gloves and applying clean gloves without performing hand hygiene. She then proceeded to wipe goggles with a bleach wipe, and removed the gloves. CNA # 2 then stated "I need to dispose of these gloves and wipes; there's no trash can." She then proceeded down the hallway to a bathroom to dispose of the items. During an interview with CNA # 2 she stated "I wasn't sure where to dispose of the used items; I should have used hand sanitizer after I took off the first pair of gloves before I put on the clean gloves..." At approximately 1:00 p.m. the administrator and DON (director of nursing) were made aware of the above observations. The DON stated that hand hygiene should be performed before entering resident rooms and prior to leaving resident rooms when delivering meal trays. She further stated that when changing gloves, hand hygiene should be performed after degloving and prior to regloving and disposed of in trash receptacle at the door. She indicated there should be a red bag inside the resident room. The DON was advised there was not a trash receptacle	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24401

(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 4 available and staff had to go down the hallway to a bathroom. The policy for hand hygiene and donning (putting on) and doffing PPE (personal protective equipment) was requested at that time. The policy "Handwashing/Hand Hygiene" included "Policy: This facility considers hand hygiene the primary means to prevent the spread of infections." Under "Policy Interpretation and Implementation" included "7. Use alcohol-based hand rub containing at least 62 percent alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...p. Before and after assisting a resident with meals..." The policy "COVID-19 Personal Protective Equipment: Doffing Step by Step" included "Doffing Step 3: Doff Gloves- Remove gloves...Doffing Step 4: Exit Patient Room..... Doffing Step 5: Perform Hand Hygiene for a minimum of 20 seconds or until hand sanitizer dry...Doffing Step 6: New gloves are donned in order to handle disinfectant wipes safely..." No further information was provided prior to exiting the facility.	F 880		