STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495330	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIER REGIONAL MEDICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323

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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted offsite from 6/15/20 through 6/17/20 and onsite on 6/23/20 through 6/24/20. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. The census in this 120 certified bed facility was 88 at the time of survey. A total of 90 residents were tested resulting in 23 confirmed cases of COVID-19. A total of 92 staff members were tested resulting in seven confirmed cases of COVID-19. There were no resident and/or staff recoveries from COVID-19 at the time of the survey	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted 6/15/20 through 6/16/20 and onsite on 6/23/20 through 6/24/20. The facility was not in compliance with F-880 of 42 CFR Part 483, Federal Long Term Care requirements. The census in this 120 certified bed facility was 88 at the time of survey. A total of 90 residents were tested resulting in 23 confirmed cases of COVID-19. A total of 92 staff members were tested resulting in 7 confirmed cases of COVID-19. There were no resident and/or staff recoveries from COVID-19 at the time of survey	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	F 880	F880 SS=D Plan of correction is prepared and execute because it is required by state and federal law. Facility provides this plan of correction without admitting or denying the validity or existence of the alleged deficiency It is alleged that the facility failed to follow infection control practices and perform hand hygiene prior to leaving a COVID-19 positive resident room.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darnell Kennon
TITLE: Administrator
(X6) DATE: 7-17-2020

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 comfortable environment and to help prevent the 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	F 880	LPN #1 is an agency nurse and no longer works for this facility. Residents have the potential to be affected by the same deficient practice. Actions taken: All nursing staff will be educated by the DON/ designee on use of gloves and hand washing. Competencies on hand hygiene will be performed. DON/designee will perform random audits on proper use of gloves / hand hygiene 4 x week for 4 weeks, 3 x week for 4 weeks and then weekly and PRN until substantial compliance is met. Findings will be reported to QAPI committee monthly and updated as indicated. Compliance date August 7, 2020. QAPI Root cause: LPN #1 during survey performed improper use of gloves and did not practice proper handwashing Plan: All nursing staff will be educated by DON/ designee on proper use of gloves and handwashing. Handwashing competencies to be performed by DON/designee Audit will be performed to check proper use of gloves as well as hand hygiene. Responsible for the plan: DON/designee Time frame: Completion within 30 days	

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F 880	Continued From page 2 circumstances. (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, it was determined that facility staff failed to follow infection control practices and perform hand hygiene prior to leaving a COVID-19 positive resident room. The findings included: On 6/23/20 at 3:15 p.m., an observation was conducted of the COVID-19 unit (Unit 100). On 6/23/20 at 4:00 p.m., LPN (Licensed Practical Nurse) #1 went up to the surveyor and stated, "I have 4 sets of gloves on so when I go in to the patients I can go remove one set of gloves and then to the next resident. LPN #1 stated, "Is that	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 3 ok to do that?" The surveyor did not provide guidance. On 6/23/20 at 4:10 p.m., an observation was made of LPN #1. LPN #1 entered Room (number). The nurse went to the resident by the window (B-bed) and provided care, removed her gloves (2 pairs) and washed her hands with soap and water. LPN #1 then donned (2) two pair of gloves (one pair on top of the other) and went to the other resident (A-bed). The nurse asked the resident in A-bed questions and then left the room without removing her gloves and performing hand hygiene. The nurse was then observed walking down the hall. LPN #1 then stopped in front of the medication cart, she removed 1 of 2 pairs of gloves and opened the bottom drawer of the medication cart and removed germicidal wipes from the container and cleaned a thermometer and stethoscope. On 6/23/20 at approximately 4:15 PM an interview was conducted with LPN #1. The above observations with LPN #1 was discussed. When asked if she should have removed her gloves and washed her hands after providing care and before leaving a resident's room, LPN #1 stated,"Yes, I should have removed my gloves and washed my hands before I left the residents room." On 6/23/20 at approximately 4:40 p.m., ASM (administrative staff member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Handwashing Policy," documents in part, the following: "...7. Use alcohol based hand rub containing at least 62	F 880		

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F 880	Continued From page 4 percent alcohol; or alternatively soap and water for the following situations...before and after entering isolation precaution settings." On 6/24/20 at 12:29 p.m. a telephone exit conference was conducted with Administrator. No further information was presented by the facility staff.	F 880		