STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E076	A. BUILDING _____ B. WING _____	C 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNYDER NURSING HOME	11 NORTH BROAD ST SALEM, VA 24153

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/09/21 through 02/11/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/09/21 through 02/11/21. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.One complaint was investigated (substantiated with deficient practice). The Life Safety Code survey/report will follow. The census in this 45 certified bed facility was 25 at the time of the survey. The final survey sample consisted of 12 current Resident reviews and 2 closed record reviews.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		3/31/21

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

Electronically Signed | 03/02/2021

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 686	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, the facility staff failed to ensure residents with pressure ulcers receive necessary treatment to promote healing as evidenced by failure to follow physician's orders for 1 of 14 residents, Resident #8. The findings included: For Resident #8, the facility staff failed to follow physician's orders for treatment to a stage II pressure area to the left buttock on 2/08/21 and 2/09/21. Resident #8's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease with Late Onset, Psychotic Disorder with Delusions due to Known Physiological Condition, Type 2 Diabetes Mellitus without Complications, Muscle Weakness Generalized, and Unspecified Urinary Incontinence. The quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/15/20 coded the resident as being severely impaired in cognitive skills for daily decision making with short term and long term memory loss in section C, Cognitive Patterns. Resident #8 was coded as being totally dependent on staff for bed mobility, transfers, toilet use, and personal hygiene. A nurse's progress note dated 2/07/21 at 7:00am, states "Found with Stage II open area to L (left) buttock - old site re-opened - See Wound sheet". Subsequent nurse's note on 2/07/21 at 11:00am states "POA (power of attorney), DON (director of nursing), MD informed of open site L buttock N.O.	F 686	Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, that the facility's residents do receive treatment and services necessary to prevent and heal pressure ulcers. On February 10, 2021, a Facility Incident Report was filed on behalf of Resident #8 and the Nursing Department. Clarification was sought from the Medical Director, Director of Nursing, and the Nurse assigned to Resident #8 pertaining to the receipt of and documentation of Resident #8's treatment order. On February 10, 2021, Resident #8 was seen by the Facility Medical Director and it was determined that no adverse outcomes were identified pertaining to this treatment and documentation error. In addition, Resident #8's POA was informed of the Physician's visit and the treatment error. On February 21, 2021, Resident #8's Stage II pressure ulcer was identified and classified in the medical record as "Healed". On February 11, 2021, the Nurse assigned to resident #8 received from the Director of Nursing; counseling and the assignment of additional training and continued education pertaining to the treatment and services necessary to prevent and heal pressure ulcers.	

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F 686	Continued From page 2 (new order) noted". "Weekly Pressure Ulcer Progress Report" entry dated 2/07/21 states in part, area to the left buttock is a reoccurred stage II measuring 1cm x 0.3cm with 0 depth with causes identified as diabetes, continuous urinary incontinence, and Alzheimer's. A signed physician's order dated 2/07/21 states "Clean open site to L buttocks with NS (normal saline) then apply Silvadene Cream bid (twice a day) and prn (as needed) til healed T.O. (telephone order) Dr. (name omitted)". Resident #8 has a current care plan focus dated 2/07/21 for "open area L buttock - tx (treatment) per order" with an intervention for "tx as ordered". Surveyor reviewed Resident #8's February 2021 TAR (treatment administration record) and was unable to locate the treatment order for the area to the left buttock. On 2/10/21 at approximately 3:05pm, surveyor spoke with LPN (licensed practical nurse) #1 and asked if they could located the order on the TAR. LPN #1 stated "I don't see it either" and "likely I forgot to write it in". In the presence of the surveyor, LPN #1 transcribed the order "Clean open site L buttock with NS Silvadene Cream bid and prn to site qd til healed" to the February 2021 TAR and initialed TAR for 1/08/21 7-3 and 1/10/21 7-3. LPN #1 stated they did the treatment at those times. The treatment was only signed as being completed once on 2/08/21 and was not signed as being completed on 2/09/21. On 2/10/21 at approximately 3:10pm, surveyor asked LPN #1 to view Resident #8's tube of	F 686	To prevent the reoccurrence of this type of deficiency, all Nurses will receive additional training and education pertaining to the treatment and services necessary to prevent and heal pressure ulcers. This training will be conducted by the Director of Nursing or her designee and Relias Learning Services. Subject matter will include, but not limited to: "The Prevention of Medical Errors and Adverse Events", "Nursing Documentation" and "Pressure Injury Assessment, Interventions, and Prevention". This training and education will be completed by March 31, 2021. On February 12, 2021, an audit of all current Resident Treatment Administration Records (TAR)was conducted by Director of Nursing. This audit determined that there were no additional deficiencies pertaining to the treatment and delivery of services necessary to prevent and heal pressure ulcers. To Prevent the reoccurrence of this type of deficiency the 11 p.m. to 7 a.m. Charge Nurse will conduct a 24hr chart review (each night) in order to validate that the transcription of Physician treatment orders are noted correctly. The 11 p.m. to 7 a.m. Charge Nurse will attest to this performance improvement measure with nightly signature on the Treatment Order Audit Form. This performance improvement measure will be effective March 1, 2021.	

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F 686	Continued From page 3 Silvadene Cream. LPN #1 pulled Resident #8's tube of Silvadene Cream from the treatment cart and removed the cap from the tube. The tube had been previously opened and there was a pressure indention on the outside of the tube. On 2/10/21 at approximately 3:15pm, surveyor notified the DON that Resident #8's treatment order to the left buttock from 2/07/21 was not transcribed to the TAR until today. On 2/11/21 at 9:55am, surveyor notified the administrator and DON of Resident #8's treatment to the left buttock not being completed as ordered. No further information regarding this issue was presented to the survey team prior to the exit conference on 2/11/21.	F 686	To prevent the reoccurrence of this type of deficiency the Director of Nursing or her designee will perform a pressure ulcer treatment and documentation compliance audit, weekly for four weeks and then monthly for two months. Any records not in compliance will be identified and the Nurse responsible will be counseled in accordance to established facility policy. This compliance audit will begin on March 4, 2021. To prevent the reoccurrence of this type of deficiency, the facility's Policy and Procedure pertaining to the transcription of physician orders and the documentation of treatments will be reviewed for revision by the Medical Director, Director of Nursing and the Administrator. This review will be completed by March 4, 2021. To prevent the reoccurrence of this type of deficiency, the Facility QA/QI and QA/PI teams will review this Plan of Correction at least quarterly for ongoing compliance. This will be an ongoing QA/QI and QA/PI measure.	
F 886 SS=E	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	F 886		3/31/21

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F 886	Continued From page 4 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: (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	F 886		

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F 886	Continued From page 5 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 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 staff interview and review of facility documents, the facility staff failed to conduct COVID-19 testing for asymptomatic staff based on the county positivity rate for 30 of 60 staff members. The findings included: The facility staff failed to conduct routine COVID-19 testing for asymptomatic staff members based on the county positivity rate for staff members that have not previously tested positive. At the time of the survey, there were no residents or staff positive for COVID-19. Testing totals in the facility indicated a cumulative total of 24 COVID-19 positive residents with three (3) deaths and a cumulative total of 30 positive staff members. On 2/09/21 at 2:15pm during the Entrance	F 886	Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, that facility does conduct COVID-19 testing. On February 11, 2021, a Facility Incident Report was filed on behalf of the Facility's Infection Control Preventionist. Clarification and guidance were sought for the testing of residents and staff with regards to community Positivity Rates and Testing Frequency. This clarification was sought from the Local Health Department's Lead Epidemiologist, Facility Medical Director, Director of Nursing, QA/QI and QA/PI Teams. On the afternoon of February 12, 2021, the facility did receive COVID-19 test results on all 30 employees. All 30 employees tested Negative for COVID-19.	

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F 886	Continued From page 6 Conference with the survey team, the administrator stated the facility is testing staff based on signs and symptoms only. Survey team requested the current county COVID-19 positivity rate, administrator stated the current rate for the City of (name omitted) is 6.7% and the facility considers themselves to be in the low range for testing. Administrator stated they are using the VDH (Virginia Department of Health) website to monitor positivity rates. Administrator further stated that on 1/06/21, all staff that had never tested positive for COVID-19 were tested using PCR testing and all results were negative. Administrator reported the facility has been testing staff members based on signs and symptoms only since the first COVID-19 vaccine was administered, which was on 1/11/21, based on guidance from the local health department and the facility medical director. Surveyor requested the county positivity rates since 11/01/20. Administrator provided the following information for the City of (name omitted): 1/09/21 - 1/22/21 8.5% and 1/23/21 - 2/05/21 6.6%. Administrator stated the rates on the VDH website only went back to this timeframe. CMS QSO-20-38-NH: August 26, 2020 documents in part, "Routine testing should be based on the extent of the virus in the community, therefore facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency" and "The facility should begin testing all staff at the frequency prescribed in the Routine Testing table based on the county positivity rate reported in the past week". Testing requirements for a county positivity rate of 5% - 10% is a minimum testing frequency of once a	F 886	On February 15, 2021, based on the recommendations of the Local Health Department, Medical Director and Infection Control Preventionist, the QA/QI and QA/PI teams approved the following performance measures: 1. "COVID-19 Community Positivity Rate Verification and Tracking Form". 2. It was agreed that the community positivity rate would be verified twice weekly. 3. Data verified would include at a minimum; Community, Community Positivity Rate, Testing Status (twice weekly, weekly or monthly:. 4. Scheduled testing dates. 5. The Medical Director, Infection Control Preventionist, Director of Nursing and Administrator will attest to this verification and its accuracy by affixing their signatures to the form. 6. Completed "COVID-19 Community Positivity Rate Verification and Tracking Forms will be maintained by the Infection Control Preventionist for a period of no less than one year from the date of verification. On February 15, 2021, a review of the facility's testing capabilities was conducted by the Infection Control Preventionist, Director of Nursing, Administrator and the Central Supply Director. This review verified that the facility does have supplies and testing capabilities. Testing capabilities include: the Rapid Detection Systems for COVID-19 utilizing the BD Veritor System and the Abbott BinaxNow System. In addition; it was verified that the facility has	

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F 886	Continued From page 7 week. Surveyor requested and received the facility policy entitled, "COVID-19 Testing Plan" which states in part: Policy: The facility will ensure compliance with federal and state guidance of performing resident and staff testing for viral respiratory illness, including COVID-19. Subsequent / Follow Up Testing 3) Following initial testing, the facility will test staff and residents, excluding those who have had positive test history at the frequency that is recommended by the local health department and based upon the prevalence of the virus in the geographical community. Specific Test Procedures 1) d) Asymptomatic Staff: test asymptomatic staff prior to employment, after return from travel to a high-risk location, upon suspicion of exposure and as required by CDC and CMS guidance. On 2/10/21 at 9:08am, survey team spoke via phone with (name omitted), epidemiology nurse with the local health department, who stated it was their understanding that if the facility is still screening staff it is okay that only new employees should be tested. Epidemiology nurse stated the facility's outbreak is over, every resident had COVID-19 and has received vaccinations. They stated they would review the CMS guidelines and their last conversation with the facility administrator and return the call to the survey team. Epidemiology nurse contacted the survey team at 9:53am and stated they looked at the CMS memo and facility should be testing once a week. They stated they do not remember talking	F 886	two Laboratory service agreements in place for PCR testing. These Laboratories are identified as ArcPoint Labs and Vista Lab. To prevent the reoccurrence of this type of deficiency, the facility's policy and procedure pertaining to its COVID-19 Testing Plan was reviewed for revision by the Medical Director, Director of Nursing, Infection Control Preventionist, Administrator and the QA/QI & QA/PI Teams. This review was completed on February 22, 2021. To prevent the reoccurrence of the type of deficiency, all Staff will receive additional training and education pertaining to the Facility COVID-19 Testing Plan. This additional training and education will include specific information pertaining to community positivity rates and testing requirements. To prevent the reoccurrence of this type of deficiency the following performance measure will be initiated. The facility will utilize its partnerships with Health Quality Innovators (HQI) and LeadingAge Virginia, for additional interpretive guidance pertaining to COVID-19 Testing. This will be an ongoing QA/QI & QA/PI measure. To prevent the reoccurrence of this type of deficiency, the Facility's QA/QI and QA/PI teams will review this Plan of Correction at least quarterly for ongoing compliance. This will be an ongoing QA/QI and QA/PI	

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F 886	Continued From page 8 to the facility about going by positivity rates for testing. On 2/10/21 at 9:58am, survey team spoke with administrator and DON (director of nursing) concerning the facility not testing asymptomatic staff based on the county positivity rates. Administrator stated staff are screened daily for signs and symptoms of COVID-19, their temperatures are checked and the 30 staff members that have remained negative are tested monthly. Administrator stated the facility has an "ample supply" of rapid COVID tests available for use. Survey team referred the facility to the CMS QSO-20-38-NH 8/26/20 memo for guidance for routine testing of staff. Administrator stated "We are going to start testing according to locality positivity rate" and "we'll start testing today". On 2/11/21 at 8:52am, surveyor asked for the results of the staff COVID-19 tests performed yesterday. Administrator stated "no one has tested positive". Surveyor spoke with the DON at 9:10am who stated 23 staff members have been tested. No further information regarding this issue was presented to the surveyor prior to the exit conference on 2/11/21.	F 886	measure.	