| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495323 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

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| HERITAGE HALL - LAUREL MEADOWS | 16600 DANVILLE PIKE LAUREL FORK, VA 24352 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 6/1/21 through 6/3/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 6/1/21 through 6/3/21. One (1) complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.<br><br>The census in this 60 certified bed facility was 50 at the time of the survey. The survey sample consisted of 13 current resident reviews and four (4) closed record reviews. | F 000 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, | F 880 | **F880**<br>**Corrective Action(s):**<br>Resident #44's attending physician has been notified that facility staff failed to implement infection control practices to prevent the spread of infection when a staff member (RN #1) failed to sanitize her hands during the treatment observation on 6/2/2.<br><br>RN #1 has received one on one education regarding handwashing. | |

VDH/OLC

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

Administrator 6/15/21

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<br>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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the | F 880 | **Identification of Deficient Practice(s) and Corrective Action(s):**<br>All residents may have the potential to be affected by improper infection control practices related to handwashing.<br>The infection preventionist will complete a review of all nursing staff for handwashing. The DON and/or designee will complete a treatment observation of all nurses who regularly complete treatments to ensure compliance with handwashing.<br>Any negative findings will be addressed immediately, and disciplinary action taken as needed.<br><br>**Systemic Change(s):**<br>The facility Infection Control policy and procedure have been reviewed and no changes are warranted at this time. The infection preventionist has inserviced all staff on handwashing.<br><br>**Monitoring:**<br>The infection preventionist is responsible for maintaining compliance. The infection preventionist will complete QA audits no less than 3 times weekly monitor for compliance.<br>Any negative findings will be corrected at the time of discovery and disciplinary action taken as needed.<br>Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure.<br><br>**Compliance Date: 06-25-2021** | |

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| F 880 | Continued From page 2<br>corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility document review, the facility staff failed to follow established infection control procedures during a wound care observation for 1 of 17 residents, Resident #44.<br><br>The findings included:<br><br>The facility staff failed to complete hand hygiene after removing gloves and after cleaning a sacral wound.<br><br>Resident #44's clinical record included the diagnosis, atrial fibrillation, chronic obstructive pulmonary disease, edema, and cognitive communication deficit.<br><br>Section C (cognitive patterns) of Resident #44's significant change in status (MDS) minimum data set assessment with an (ARD) assessment reference date of 05/07/2021 included a (BIMS) brief interview for mental status summary score of 12 out of a possible 15 points. Section M (skin) had been coded to indicate Resident #44 had a stage 2 pressure ulcer.<br><br>Resident #44's clinical record included a | F 880 | | |

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| F 880 | Continued From page 3<br>physician order dated 05/20/2021 to cleanse stage 2 to sacrum with dermal wound cleanser, pat dry, apply calcium ag and comfort foam to wound every day and (PRN) as needed until resolved.<br><br>06/02/2021 2:14 p.m., wound care observation with (RN) registered nurse #1. RN #1 was observed to wash their hands and apply a clean pair of gloves, remove old dressing, wash their hands, apply a clean pair of gloves, clean the wound with dermal wound cleanser, change their gloves, cut a piece of calcium ag, predate the comfort foam border gauze, put the calcium ag into the wound bed, and apply the foam dressing.<br><br>06/02/2021, the (RNC) regional nurse consultant provided the surveyor with a copy of their policy titled "Handwashing/Hand Hygiene." This policy read in part, "...Use an alcohol-based hand rub...or, alternatively, soap...and water for the following situations...Before handling clean or soiled dressings, gauze pads...Before moving from a contaminated body site to a clean body side during resident care...After removing gloves ..."<br><br>06/02/2021 3:45 p.m., RN #1 stated they did not wash their hands after cleansing the wound.<br><br>06/02/2021 4:35 p.m., the infection control issue was reviewed with the regional vice president of operations, RNC, administrator, and (DON) director of nursing during an end of the day meeting.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference. | F 880 | | |

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