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

PRINTED: 11/19/2021 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		SURVEY PLETED
		495306	B. WING			C / 15/2021
	ROVIDER OR SUPPLIER GE THERAPY CONNECT	TION	STREET ADDRESS, CITY, STATE, ZIP CODE 105 LANDMARK DRIVE STUART, VA 24171		10,2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
F 000	COVID-19 Focused S Medicare/Medicaid al conducted 09/14/202 facility was in substar Part 483.73, Requirer Facilities. On 09/14/2021, the co bed facility was 136. Residents and 5 staff COVID-19. INITIAL COMMENTS An unannounced Me survey and COVID-19 conducted 09/14/202 complaint was investi (unsubstantiated). Co compliance with 42 C Term Care requireme The census in this 19 136. The survey sam Residents reviews (R	obreviated survey was 1 through 09/15/2021. The Itial compliance with 42 CFR ment for Long-Term Care ensus in this 190 certified The facility staff reported 8 were positive for dicare/Medicaid abbreviated 9 Focused Survey was 1 through 09/15/2021. One gated during the survey rrections are required for FR Part 483 Federal Long ints. 0 certified bed facility was tole consisted of 2 current esident #1 and #2) and 1	F 0	00		
F 886 SS=D	On 09/14/2021 the fa Residents and 5 staff COVID-19. COVID-19 Testing-Re CFR(s): 483.80 (h)(1)	cility staff reported 8 were positive for esidents & Staff	F 8	86		10/15/21
ABORATORY	must test residents ar individuals providing and volunteers, for Co	9 Testing. The LTC facility and facility staff, including services under arrangement OVID-19. At a minimum,		TITLE		(X6) DATE

10/11/2021 **Electronically Signed** 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

Facility ID: VA0038

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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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		495306	B. WING	_		·	C 15/2021
	ROVIDER OR SUPPLIER GE THERAPY CONNECT	l		1	STREET ADDRESS, CITY, STATE, ZIP CODE 105 LANDMARK DRIVE STUART, VA 24171	03/	13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 886	and volunteers, the Li §483.80 (h)((1) Cond parameters set forth I but not limited to: (i) Testing frequency; (ii) The identification of this paragraph diagnor COVID-19 in the facil (iii) The identification this paragraph with succonsistent with COVID suspected exposure to (iv) The criteria for consymptomatic individing paragraph, such as the COVID-19 in a counting (v) The response time (vi) Other factors specified help identify and previous producting COVID-19 in a counting conducting COVID-19 §483.80 (h)((2) Condition is consistent with curronducting COVID-19 §483.80 (h)((3) For each conducting COVID-19 §483.80 (h)((3) For each conducting covider that testing conducting covider to the resident's testing each test.	acility staff, including services under arrangement TC facility must: uct testing based on by the Secretary, including of any individual specified in osed with ity; of any individual specified in symptoms D-19 or with known or to COVID-19; inducting testing of uals specified in this ine positivity rate of the specified by the Secretary that item the D-19. uct testing in a manner that trent standards of practice for tests; ach instance of testing: ting was completed and the est; and esident records that testing	F	886			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C 09/15/2021	
		495306	B. WING_				
	ROVIDER OR SUPPLIER GE THERAPY CONNEC			STREET ADDRESS, CITY, STATE, ZIP COD 105 LANDMARK DRIVE STUART, VA 24171			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 886	for COVID-19, take a transmission of COVID-19. The facility staff only nostril when the instruction of COVID-19, take a transmission of COVID-19 test for only nostril when the instruction of COVID-19 test for only nostril when the	this paragraph with D-19, or who tests positive ctions to prevent the ID-19. procedures for addressing including individuals providing gement and volunteers, who unable to be tested. In necessary, such as in resting supply shortages, artments to assist in testing ining testing supplies or its. In is not met as evidenced on, staff interview, and facility is facility staff failed to control program designed to the transmission of the transmission of the staff failed to follow the nes when obtaining a rapid is of one employee. It is die to obtain a COVID-19 rapid manufactures instructions, obtained a sample from one facility of the country instructions and the country instructions the country instructions.	F 8	CORRECTION TO EMPLOY AFFECTED: Employee #1 – The employer retested with both nostrils permanufacturer directions. The was negative. The employee the testing completed a comprapid testing and return demonstrating correctly. IDENTIFICATION OF OTHER The Director of Nursing or de identify others at risk by perform competencies with all staff the COVID testing of employees	e was test result performing betency for onstrated RS AT RISK: signee will orming at perform		
	using the BinaxNOW system.	nostrils. The facility was COVID-19 Ag Card test ., the surveyor observed		residents. ROOT CAUSE: After a full review it was found competency check off did not			

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NAME OF PROVIDER OR SUPPLIER BLUE RIDGE THERAPY CONNECTION (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 886 Continued From page 3 (RN) registered nurse #1 obtain a COVID-19 sample from employee #1. RN #1 swabbed employee #1's right nostril and placed the swab into the test card for processing. After this observation, the surveyor asked for the	E SURVEY IPLETED	COMP	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	T OF DEFICIENCIES OF CORRECTION	
BLUE RIDGE THERAPY CONNECTION (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 886 Continued From page 3 (RN) registered nurse #1 obtain a COVID-19 sample from employee #1. RN #1 swabbed employee #1's right nostril and placed the swab into the test card for processing. After this observation, the surveyor asked for the	C 9/15/2021		;	B. WING	495306		
STUART, VA 24171		·	STR	•		PROVIDER OR SUPPLIER	NAME OF P
STUART, VA 24171)5 LANDMARK DRIVE	105		TION	IDGE THEDADY CONNEC.	BI HE DID
F 886 Continued From page 3 (RN) registered nurse #1 obtain a COVID-19 sample from employee #1's right nostril and placed the swab into the test card for processing. After this observation, the surveyor asked for the		TUART, VA 24171	STU		HON	IDGE THERAFT CONNEC	BLUE KID
(RN) registered nurse #1 obtain a COVID-19 sample from employee #1. RN #1 swabbed employee #1's right nostril and placed the swab into the test card for processing. After this observation, the surveyor asked for the swab both nostrils. The employee performing the testing did not read the instruction manual located in the testing kit prior to testing Employee #1. SYSTEM CHANGE:	(X5) COMPLETION DATE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	FIX	PREFI	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC	PRÉFIX
instructions. Page two of these instructions read in part, " To collect a nasal swab sample, Firmly sample the nasal wall by rotating the swab in a circular path against the nasal wall Using the same swab, repeat sample collection in the other nostril" RN #1 confirmed that they only used one nostril when obtaining the sample and stated they were instructed to use one nostril. RN #1 stated I will do both from now on. 09/15/2021 The (IP) infection preventionist provided the surveyor with a signed consent from employee #1 and stated this employee was retested and was negative. The IP also provided the surveyor with a skill check off regarding the BinaxNow COVID-19 Ag Card testing. This skill check off was signed by RN #1. Number 5 on this form read in part, " Using the same swab repeat the collection procedure with the second nostril" No further information regarding this issue was provided to the surveyor prior to the exit conference. The competency check off for rapid COVID testing using the Abbott testing kit was updated per current guidelines. The Director of Nursing or designee will ensure all employees that perform rapid testing of employees or residents will perform the competency correctly and educated on the importance of reading manufacturer instructions located in test kit prior to starting testing. Educational Resource: https://www.dc.gov/coronavirus/2019-nco v/lab/point-of-care-testing.html https://www.fda.gov/media/141570/downlo ad MONITORING PROCESS: Director of Nursing or designee will observe 10% of employees being tested via rapid COVID-19 test kits weekly x4 weeks, biweekly x2 weeks, monthly x2 months and then PRN to ensure correct technique is used. Analysis of monthly data will be reported to QAPI for additional oversight and guidance.		performing the testing did not read the instruction manual located in the testing kit prior to testing Employee #1. SYSTEM CHANGE: The competency check off for rapid COVID testing using the Abbott testing kit was updated per current guidelines. The Director of Nursing or designee will ensure all employees that perform rapid testing of employees or residents will perform the competency correctly and educated on the importance of reading manufacturer instructions located in test kit prior to starting testing. Educational Resource: https://www.cdc.gov/coronavirus/2019-nco v/lab/point-of-care-testing.html https://www.fda.gov/media/141570/downlo ad MONITORING PROCESS: Director of Nursing or designee will observe 10% of employees being tested via rapid COVID-19 test kits weekly x4 weeks, biweekly x2 weeks, monthly x2 months and then PRN to ensure correct technique is used. Director of Nursing or designee will observe 10% of residents being tested via rapid COVID-19 test kits weekly x4 weeks, biweekly x2 weeks, monthly x2 months and then PRN to ensure correct technique is used. Analysis of monthly data will be completed and findings will be reported to QAPI for		F	e #1 obtain a COVID-19 ee #1. RN #1 swabbed nostril and placed the swab processing. In the surveyor asked for the octions. Page two of these art, " To collect a nasal sample the nasal wall by a circular path against the e same swab, repeat sample er nostril" If they only used one nostril ample and stated they were nostril. RN #1 stated I will Infection preventionist er with a signed consent from ted this employee was gative. The IP also provided kill check off regarding the er Ag Card testing. This skill by RN #1. Number 5 on this Using the same swab repeat ure with the second nostril" In the IP stated RN #1 should ostrils. In regarding this issue was	(RN) registered nurse sample from employe employee #1's right rinto the test card for particle and the test card for particl	F 886