STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 01/20/2022

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RURAL RETREAT CARE CENTER	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted onsite 1/19/2022. A complaint was investigated and relevant portions of the Emergency Preparedness program were reviewed. Corrections are required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirements. On 1/19/2022, the census in this 120 certified bed facility was 98. Of the 98 current residents, none had currently tested positive for the COVID-19 virus. Two current staff had members had tested positive during the outbreak and one of them had returned to work after home isolation. The survey sample consisted of three current resident reviews.	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 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	F 880		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/31/2022

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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.
(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.

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§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 observations, interviews, and document review, the facility staff failed to properly implement transmission based precautions (TBP) to address COVID-19 concerns with residents recently admitted and/or readmitted to the facility. Two (2) of seven (7) staff members were observed entering a room, identified as requiring the use of eye protection, gowns, and gloves, without wearing the required personal protective equipment (PPE).

The findings include:

The Administrator and the DON were interviewed during the Survey Entrance Conference on 1/19/22 at 11:25 a.m. They reported the facility did not currently have any residents who were positive for COVID-19. They reported that 12 residents are in "warm" areas of the building, which required anyone entering the "warm" areas to don N95 masks, eye protection, gowns, and gloves. The 12 residents were in "warm" rooms because of recent admissions/readmissions and/or frequent trips to appointments outside the facility.

On 1/19/22 at 1:40 p.m., Staff Member (SM) #21 and SM #22 were observed in a resident room

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that had a sign posted identifying it as a "warm" room. They were talking with the resident in the bed near the window. Both SM #21 and SM #22 were wearing N95 masks. While in this "warm" room, neither SM #21 nor SM #22 were wearing eye protection, gowns, and gloves. The sign posted outside of this room included the following statements: warm room, PPE (personal protective equipment) required, and see nurse before entering. The facility's Administrator provided the surveyor with a copy of one of these signs on 1/19/22 at 2:02 p.m. SM #22 was observed reentering this "warm" room on 1/19/22 at 1:55 without donning eye protection, a gown, or gloves. This room was a "warm" room because a resident in this room had been admitted or readmitted to the facility within the previous 14 days.

On 1/19/22 at 1:59 p.m., the Administrator and the Direction of Nursing (DON) observed the aforementioned room where staff members were noted to enter without wearing eye protection, gowns, and gloves. The DON confirmed anyone entering the room would need to wear eye protection, gowns, gloves, and N95 masks.

The facility's Administrator provided a policy titled "Novel Coronavirus Prevention and Response" (this document was not dated). The Administrator directed the surveyor to the section of this policy that read as follows: " ... e. Educate staff on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precautions, including eye protection. f. Promote easy and correct use of personal protective equipment (PPE) by: i. Posting signs on the door or wall outside of the resident room that clearly describe the type of

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F 880	Continued From page 4 precautions needed and required PPE. ii. Make PPE, including facemask, eye protection, gowns, and gloves, available immediately outside of the resident's room. iii. Position a trash can near the exit inside any resident room to make it easy to discard PPE." On 1/20/22 at 1:20 p.m., the failure of two (2) staff members to wear the required PPE when entering a "warm" room was discussed for a final time with the facility's Administrator, DON, and Assistant DON.	F 880		
F 886 SS=D	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 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	F 886		

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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 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 observations, interviews, and

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document review, the facility staff failed to properly implement COVID-19 testing processes to attempt to prevent transmission. Observation of three (3) of three (3) staff members, completing COVID-19 testing, revealed specimen collections were not obtained according to manufacturer's instructions.

The findings include:

On 1/20/22 at 8:29 a.m., Staff Member (SM) #23 was observed completing their own COVID-19 test. SM #23 was observed collecting their nasal swab sample by inserting the swab for less than 10 seconds in each of their nares. SM #23 reported they rotated the swab four (4) times in each naris. On 1/20/22 at 9:25 a.m., SM #23 reported they had not been provided instruction about a length of time required for the specimen collection.

On 1/20/22 at 9:12 a.m., SM #24 was observed completing their own COVID-19 test. SM #24 was observed collecting their nasal swab sample by inserting the swab for less than 10 seconds in each of their nares. SM #24 reported they rotated the swab for six (6) seconds in each naris.

On 1/20/22 at 9:13 a.m., SM #25 was observed to complete their own COVID-19 test. SM #25 was observed collecting their nasal swab sample by inserting the swab for less than 10 seconds in each of their nares. SM #25 reported they rotated the swab four (4) times in each naris. SM #25 reported they had not been provided instruction about a length of time required for the specimen collection.

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The following information was found in the manufacturer's instructions for use: "Anterior Nasal (Nares) Swab ... Only the swab provided in the kit is to be used for nasal swab collection. To collect a nasal swab sample, carefully insert the entire absorbent tip of the swab (usually ½ to ¾ of an inch (1 to 1.5 cm) into the nostril. [sic] Firmly sample the nasal wall by rotating the swab in a circular path against the nasal wall 5 times or more for a total of 15 seconds, then slowly remove from the nostril. Using the same swab, repeat sample collection in the other nostril." On 1/20/22 at 9:30 a.m., the facility's Administrator and Director of Nursing (DON) confirmed these were the correct instructions for the COVID-19 tests the facility was using. The aforementioned observations were shared with the facility's Administrator and DON.

The facility's policy and procedure with the topic of "COVID-19 Testing Plan" (with an initial date 8/5/21) included the following information: "The screening and testing will be conducted in a manner consistent with current standards of practice for COVID-19 to facilitate effective interventions for rapidly detecting and preventing the transmission of COVID-19."

On 1/20/22 at 1:20 p.m., the observations of three (3) staff members failing to correctly obtain a COVID test specimen with a nasal swab was discussed for a final time with the facility's Administrator, DON, and Assistant DON.