STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495425	A. BUILDING _____ B. WING _____	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REHAB CENTER AT BRISTOL	301 VILLAGE CIRCLE BRISTOL, VA 24201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/06/2020 through 10/09/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS A unannounced COVID-19 Focused Infection Control Survey was conducted onsite on 10/06/2020 and offsite 10/06/2020 through 10/09/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Corrections are not required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). The census in this 90 certified bed facility was 51 at the time of the onsite survey. At the time of the survey 3 residents and 2 staff were positive for COVID-19. Six residents had expired 5 in house and 1 at a local hospital. The survey sample consisted of 3 current resident reviews, Residents #1, #2 and #3.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		

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

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 684	Continued From page 1	F 684		

Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure
that residents receive treatment and care for 1 of 3 residents, Resident #2. The facility staff failed to obtain the residents vital signs this was a positive COVID-19 resident that had recovered.

The findings included:

The facility staff failed to obtain the residents VS (vital signs) 09/15-10/01/2020. The resident was positive for COVID-19 on 09/03/2020 and had since recovered.

Resident #2's clinical record included, but was not limited to, the diagnoses, COVID-19 (09/03/2020) and Parkinson's disease.

Section C (cognitive patterns) of the residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/07/2020 included a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points.

The residents comprehensive care plan included the intervention obtain vitals as indicated. Report any presence of fever and low-level oxygen saturation.

Resident #2 had tested positive for COVID-19 on 09/03/2020, was placed on enhanced droplet precautions and transferred to the COVID-19 positive unit (HOT unit). Resident #2 remained on this unit until 09/30/2020.

During the clinical record review, the surveyor was unable to locate the resident VS for

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F 684	Continued From page 2	F 684		

09/15-10/01/2020.

On 10/07/2020 at 12:10 p.m., during a phone call with the administrator, the surveyor asked for any VS information for Resident #2 prior to 10/02/2020.

The surveyor brought the missing VS to the attention of the DON (director of nursing) on 10/08/2020 at 2:00 p.m. The DON verbalized to the surveyor that the VS should be done at least daily.

On 10/08/2020 at 3:55 p.m., the DON verbalized to the surveyor that the resident was slower to recover than some of the other residents and had not been removed from precautions until 09/30/2020. The DON also verbalized to the surveyor that they did not see any VS for the timeframe of 09/15-10/01/2020.

On 10/09/2020 at 10:40 a.m., during a phone interview with the DON and administrator, the DON verbalized to the surveyor that she was unable to find any VS for the above dates and they did not have a policy on obtaining VS. The DON also added that for skilled residents VS should be taken every shift and for a resident on droplet precautions the VS should be taken each shift unless the physician had wrote a specific order. Resident #2's clinical record did not include a specific order for VS.

The facility did provide the surveyor with a copy of a policy titled "Novel Coronavirus Prevention and Response." This policy read in part, "...The facility will monitor all residents daily for s/s (signs/symptoms) of COVID-19..."

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F 684	Continued From page 3 No further information regarding this issue was provided to the surveyor prior to the exit conference on 10/09/2020.	F 684		