STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	11/25/2020

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RICHFIELD: HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD SALEM, VA 24153

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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 11/04/2020. Emergency Preparedness information was reviewed off-site between 11/05/2020 and 11/25/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. On 11/04/2020, the census in this 280 certified bed facility was 142. Of the 142 current residents, 28 were positive for COVID-19 during the onsite portion of the survey. Eleven (11) of the facility's staff members had tested positive for COVID-19.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted onsite on 11/04/2020. Infection control information was reviewed off-site between 11/05/2020 and 11/25/2020. Corrections are required for compliance with F-880 and F-886 of 42 CFR Part 483 Federal Long Term Care requirement(s). On 11/04/2020, the census in this 280 certified bed facility was 142. Of the 142 current residents, 28 were positive for COVID-19 during the onsite portion of the survey. Eleven (11) of the facility's staff members had tested positive for COVID-19.	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	F 880		1/6/21

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

Electronically Signed | 12/14/2020

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F 880	Continued From page 1	F 880		

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 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

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F 880	Continued From page 2 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. §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 staff interviews and facility document review it was determined the facility staff failed to consistently document COVID-19 staff screening, which did not allow for the identification of COVID-19 symptoms prior to working, for Staff Member #3 on one (1) of five (5) days worked during a six week period. The findings: Facility staff failed to document COVID-19 screening for Staff Member (SM) #3 prior to working on 11/06/2020. Staff Member #3, a licensed practical nurse (LPN), was interviewed in person during onsite	F 880	Corrective Action: PCR test completed on Employee #3 Identification of Deficient Practice: Failure to correctly store and retain daily screening forms of staff on 11/6/2020. Systemic Changes: A) Collect and count all screening forms per shift to validate completion and accurate count of staff. B) After daily log is completed by receptionist, the screening forms will be filed by date in Human Resources office.	

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F 880	Continued From page 3 observations on 11/04/2020. When asked, the LPN indicated he/she was an agency staff member and had not been tested for COVID-19. The facility's administrator provided evidence SM #3 had previously tested positive for COVID-19 in May 2020. On 11/20/2020 at 1:34 p.m. the local epidemiologist stated during a phone conversation with the surveyor, they did not advise retesting previously COVID-19 positive staff members, even after 90 days following their positive result, unless the staff member becomes symptomatic. Upon request, the administrator provided the dates SM #3 had worked between October 2020 and November 18, 2020 as well as the evidence of COVID-19 screening prior to working. SM #3 had worked five (5) days: 1) 10/16/2020, 2) 10/21/2020, 3) 11/03/2020, 4) 11/04/2020, and 5) 11/06/2020. Of the five (5) days SM #3 worked, the administrator was able to provide evidence SM #3 was asymptomatic prior to working for four (4) of the five (5) days. In a phone conversation with the administrator and director of nursing (DON) on 11/25/2020, both stated they had gone through thousands of sheets looking for the missing COVID-19 screening sheet but could not find either SM #3's individual screening sheet or the cumulative log sheet for the missing day (11/06/2020). Therefore, there was no provided documented evidence SM #3 was not symptomatic on 11/06/2020. No further information was provided to the surveyor prior to the exit conference via phone with the administrator and DON on 11/25/2020.	F 880	Monitoring: Audit to be completed by Human Resources weekly x 4 weeks then biweekly x 4 weeks to ensure accuracy. Date of Compliance: January 6, 2021 Title Responsible: Human Resources Coordinator	
F 886 SS=D	COVID-19 Testing-Residents & Staff	F 886		1/6/21

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F 886	Continued From page 4 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 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	F 886		

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F 886	Continued From page 5 (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 staff interviews and facility document review it was determined the facility staff failed to consistently test and/or document previously reported COVID-19 testing results for one (1) of three (3) staff members sampled for COVID-19 testing review (Licensed Practical Nurse, LPN Staff Member #3). The findings: The facility staff failed to test Staff Member #3 (SM #3) for COVID-19 or ensure previous testing results were documented and provided to the facility prior to working.	F 886	Corrective Action: 100% audit on those that have been positive. If more than 90 days then they are to test as scheduled like those that continue to be negative. Also, we have a spreadsheet on when those that are approaching 90 days will need to test. Staff will continue to screen each day they work when entering the facility. Identification of Deficient practice: Facility failed to have positive results from employee #3 which occurred in May 2020.	

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F 886	Continued From page 6 During the onsite entrance conference with the facility administrator and director of nursing (DON) on 11/04/2020, the administrator stated the facility was currently in outbreak mode and were testing staff for COVID-19 twice a week. On 11/04/2020 in the afternoon while touring the facility with the administrator and DON, a licensed practical nurse (SM #3) was randomly chosen for an interview. When asked, the LPN informed the surveyor he/she was an agency nurse and had not been tested for COVID-19. Prior to leaving the facility property, the surveyor requested the administrator send evidence of COVID-19 testing for three (3) facility employees to include SM #3. On 11/09/2020 the administrator faxed approximately 100 pages of requested information to include personnel COVID-19 testing results and that information was reviewed by this surveyor on 11/16/2020. Although the faxed information included personnel COVID-19 testing results for two (2) of the staff members requested, it did not include any information related to SM #3. The administrator was informed of the missing documentation during a phone call on 11/16/2020 at 4:44 p.m. The administrator faxed SM #3's testing documentation on 11/18/2020. The documentation included a letter from a Virginia health district to SM #3 dated 11/17/2020 that stated SM #3 had tested positive for COVID-19 on 05/29/2020. There was also a letter from the same health district to SM #3 dated 07/01/2020 that read SM #3 had tested negative for COVID-19 on 06/26/2020. Evidence SM #3 tested negative for COVID-19 on 11/10/2020 was also provided. Upon request, the administrator	F 886	Systemic Changes: A) Facility to follow CDC guidelines of testing those previously positive after 90 days for COVID-19. Facility was following direction of local VDH to test only those symptomatic if they were already positive. Monitoring: Facility to keep updated spreadsheet on those that test positive and when they need to start testing again after 90 days form their positive date. This is following CDC guidelines. Date of Compliance: January 6, 2021 Title Responsible: Infection Preventionist	

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provided the dates SM #3 had worked between October 2020 and November 18, 2020; 1) 10/16/2020, 2) 10/21/2020, 3) 11/03/2020, 4) 11/04/2020, and 5) 11/06/2020.

During a phone conversation with the administrator on 11/19/2020 at 2:16 p.m., SM #3's COVID-19 testing evidence was discussed. The administrator stated the health district who had tested SM #3 in May and June 2020 had not wanted to release the information to the facility. The administrator stated that prior to the 11/11/2020 test results (from 11/10/2020 test) SM #3 had not been tested twice a week even though it had been over 90 days since the nurse's COVID-19 positive test. The administrator said the nurse may not have realized he/she should have been tested starting 90 days following the positive test result in May 2020 and acknowledged the administrative team was ultimately responsible for verifying agency staff were tested or provided proof of testing prior to working. The administrator said SM #3 might be one that slipped through the cracks.

On 11/20/2020 at 1:34 p.m. the local epidemiologist stated during a phone conversation with the surveyor, they did not advise retesting previously COVID-19 positive staff members, even after 90 days following their positive result, unless the staff member becomes symptomatic.

Upon request, the administrator provided the surveyor with SM #3's COVID-19 screening sheets for the days worked October 2020 through November 18, 2020. Of the five (5) days SM #3 worked, the administrator was able to provide evidence SM #3 was asymptomatic prior to

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F 886	Continued From page 8	F 886		

working for four (4) of the five (5) days the LPN worked. (See also tag F-880). In a phone conversation with the administrator and DON on 11/25/2020, both stated they had gone through thousands of sheets looking for the missing screening sheet but could not find either SM #3's individual screening sheet or the cumulative log sheet for that day (11/06/2020).

The facility's policy titled, "COVID-19 Testing" effective June 2020 with a revision date of September 2020, read, "Outbreak Testing: Test all staff and residents in response in response [sic] to an outbreak (any single new infection). Continue to test all staff and residents that tested negative every 3-7 days until 14 days since the most recent positive result has passed. Once this has been completed, refer back to Routine Testing for frequency of staff. (Outbreak is defined as 1 case per CMS)
If the county positivity rate decreases the facility should continue testing at the higher frequency level for at least two weeks.
If the country's positivity increases the facility will immediately adjust to that testing frequency."

The policy also listed:
if the Community COVID-19 Activity was LOW (less than 5%), the minimum testing frequency was once a month; if the Community Activity was MEDIUM (5%-10%), the minimum testing was once a week and; if the Community was HIGH, the minimum testing was twice a week.

The policy did not address staff who had previously testing positive for COVID-19.

No further information was provided to the surveyor prior to the exit conference which took

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F 886	Continued From page 9 place over the phone with the administrator and DON on 11/25/2020.	F 886		