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	495406	A. BUILDING _____ B. WING _____	11/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	1000 LITTON LANE BLACKSBURG, VA 24060

(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 COVID-19 Focused Survey was conducted 10/28/20 through 11/05/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted 10/28/20 through 11/05/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Upon entrance on 10/28/20, the census in this 60 certified bed facility was 42. Of the 42 current residents, 22 residents were positive for COVID-19. Eight (8) staff members were also positive. Cumulative testing totals in the facility indicated a total of 24 COVID-19 positive residents with one (1) death. A cumulative total of nine (9) staff members have tested positive. By closure of the survey, an additional six (6) residents and three (3) staff members were reported positive. Three (3) additional resident deaths were also reported.	F 000		
F 880 SS=E	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.	F 880		

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

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F 880	Continued From page 1 §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 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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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 observations, staff interviews, and facility document reviews, the facility failed to develop written standards, policies, and procedures for an Infection Prevention and Control Program related to transmission based precautions to be followed to prevent the spread of infections.

At the time of the survey, there was a cumulative total of 24 COVID-19 positive residents with one death.

The facility failed to have a policy and procedure or written standards related to the practice of direct care staff wearing the same set of disposable coveralls and spraying the coveralls with a disinfectant between care of COVID-19 negative residents residing on the warm unit.

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The findings included:

On 10/28/20 at approximately 10:35am, the surveyor, accompanied by the administrator, observed direct care staff on the warm unit wearing white coveralls and walking outside to the patio at the end of the hall and spraying coveralls down with an aerosol spray between resident rooms. Staff were wearing the coveralls while spraying them with the aerosol spray. Surveyor observed the aerosol can and the label stated it was a disinfectant.

On 10/28/20, surveyor requested the manufacturer information for the coveralls and any guidance related to the practice of disinfecting the coveralls between residents. On 10/29/20 at 1:20pm, the administrator stated the coveralls were sent to the facility and all the information they have is the cardboard insert from the package. Surveyor received a copy of the package insert from the coveralls, which states in part, Otimed, model TK-55 LMN Disposable Coverall, breathable fabric, non-woven spun-bound fabric, and laminated film. Insert also states, "This product should not be used in a surgical setting or where significant exposure to liquid bodily or other hazardous fluids may be expected. This product should not be used in a clinical setting where level 3 or 4 protection is warranted, or in any setting involving invasive procedures or where there is a high risk of contamination."

On 10/29/20 at 10:00am, surveyor spoke with RN (registered nurse) #1 who stated gowns or coveralls are worn when caring for residents that are positive or suspected of being positive for COVID-19. RN #1 stated if a gown is worn, it

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must be changed between each resident and if coveralls are worn, they are sprayed with a disinfectant after each resident. When asked if there was a shortage of PPE (personal protective equipment) in the facility, RN #1 stated no, "we're blessed".

On 10/29/20 at 11:45am, surveyor spoke with the IP (infection preventionist) who stated the facility has maintained their PPE supplies and are always getting more in. IP stated the biggest PPE issue is the facility does not have access to all types of N95 masks. IP stated staff just started wearing the coveralls and they are only available in one size. IP also stated staff that are unable to wear the coveralls due to available sizing are continuing to wear gowns. IP further stated gowns are changed between resident rooms but coveralls are not; coveralls are sprayed with a cleaner and staff are rubbing sanitizer on suit arms between rooms on the warm and hot units.

On 10/29/20 at 1:43pm, surveyor spoke with the DON (director of nursing) who stated they could not find any guidance for the practice of spraying disinfectant on the coveralls between residents. DON also stated they were concerned that the chemicals may alter the fibers in the suits. DON stated staff were advised to use one suit per day and then throw away. DON asked if the surveyor found any guidance on the practice of disinfecting coveralls would surveyor share it with them.

On 10/29/20 at 2:02pm, surveyor spoke with the local epidemiologist concerning the facility practice of disinfecting disposable coveralls between residents. Local epidemiologist stated they do not have a problem with this practice as

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long as the facility is using an EPA approved disinfectant, getting all surfaces of the coveralls with the disinfectant, and following the recommended disinfectant contact time. Epidemiologist stated ideally, it would be better to use one set of coveralls per employee, per resident but the act of donning and doffing the coveralls incorrectly may be a greater risk.

Surveyor spoke with CNA (certified nursing assistant) #1 on 10/29/20 at 2:17pm. CNA #1 stated they wear the same body suit throughout the shift and sprays the suit after each room either in the hallway or outside. CNA #1 also stated they get a new body suit each day. When asked how long they have been wearing the white coveralls, CNA #1 stated not too long ago, on either 10/24/20 or 10/26/20.

On 10/30/20 at 11:04am, surveyor spoke with the administrator about the concern of staff disinfecting the coveralls between residents; administrator stated that the day of the surveyor onsite visit was the first time they had seen staff disinfecting the coveralls between residents. Surveyor requested any information related to the efficacy of spraying the coveralls with a disinfectant between residents, administrator stated, "I just don't have anything". Administrator further stated that someone on staff suggested it and they ran with it.

The administrator stated they are unsure if the facility has enough isolation gowns to throw away after each resident encounter but they do have enough for each staff member to wear one gown per resident per shift.

On 10/30/20 at 12:27pm, surveyor requested and

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received the manufacturer's information for the spray disinfectant being used, the Safety Data Sheet for Champion Sprayon Spray Disinfectant Formula 3 states in part, the recommended use is for the disinfection of hard, non-porous, inanimate surfaces. The chemical nature is an aqueous solution of alcohol and other active ingredients. The weight percentage of ethyl alcohol is 30-35%.

According to the United States EPA List N: Disinfectants for Coronavirus (COVID-19), Champion Sprayon Spray Disinfectant Formula 3 is a ready to use formulation for hard nonporous surfaces and requires a contact time of 10 minutes. Active ingredients are quaternary ammonium and ethanol (ethyl alcohol).

On 11/02/20 at 4:48pm, surveyor spoke with the facility Risk Management/QA staff member who stated another building shared the practice of disinfecting the disposable coveralls with the DON and they will look for any written guidance.

On 11/03/20, the administrator provided the facility policy entitled, "Optimizing the Supply of Isolation Gowns during COVID-19 Pandemic" which states in part:
Contingency Capacity
Shift gown use to cloth isolation gowns if possible (reusable, washable gowns made of polyester or polyester cotton fabrics)
Identify need for augmented laundry facilities and personnel
Routinely inspect and maintain integrity of reusable cloth isolation gowns and replace when necessary
Coveralls: As an alternative to cloth gowns, consider the use of coveralls
Train employees in use

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F 880	Continued From page 7 See requirements: NFPA 1999: https://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards/detail?code=1999 Use gowns expired beyond the manufacturer-designated shelf life Inspect gown for integrity for use Gowns or coveralls that conform to international standards can be considered Crisis Capacity Facility can consider extended use of isolation gowns: Same gown is worn by the same employee when caring for more than one resident known to be infected with the same infection in the same location unless a resident has a co-infectious diagnosis transmitted by contact (i.e. c.diff) If gown is visibly soiled, remove and discard Re-use of isolation gowns: Disposable gowns will not be re-used Cloth isolation gowns can be considered for re-use As part of standard precautions unless visibly soiled Single employee use of the gown caring for multiple residents is preferred Minimize exposures. Have gowns that are visibly soiled removed and laundered No further information regarding this issue was presented to the surveyor prior to the remote exit conference on 11/05/20.	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	F 886		

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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
(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.

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§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 review of facility documents, the facility staff failed to conduct COVID-19 testing for asymptomatic staff based on the county COVID-19 positivity rate for one (1) of five (5) staff members, CNA (certified nursing assistant) #1.

The findings included:

The facility failed to conduct COVID-19 routine testing on CNA #1 on two (2) separate occasions.

At the time of the survey, there was a cumulative total of 24 COVID-19 positive residents with one death and a cumulative total of nine (9) positive staff members.

The facility reported their county COVID-19

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positivity rates as follows:
9/07/20 - 23.9%
9/14/20 - 18.6%
9/21/20 - 23.9%
9/28/20 - 13.6%

CMS QSO-20-38-NH: August 26, 2020 documents in part, "Routine testing should be based on the extent of the virus in the community, therefore facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency" and "The facility should begin testing all staff at the frequency prescribed in the Routine Testing table based on the county positivity rate reported in the past week". Testing requirements for a county positivity rate of 5% - 10% is a minimum testing frequency of once a week and over 10% is twice a week testing for staff.

A review of CNA #1's COVID-19 testing results for the week of 9/13/20 through 9/19/20 revealed only one COVID-19 screening test for this time period. CNA #1 was tested on 9/19/20 and the results were negative. During the week of 9/27/20 through 10/03/20, CNA #1 received one screening COVID-19 test, which was negative on 10/02/20.

On 11/02/20 at 11:03am, surveyor spoke with the administrator and requested any additional COVID-19 test results for CNA #1 for the weeks of 9/13/20 through 9/19/20 and 9/27/20 through 10/03/20. At 1:40pm, surveyor received an email response from the administrator stating in part, "I looked through our records and unfortunately do not have any other test results to give you. I also do not have any documented reasons for why testing was not done on those days for those

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F 886	Continued From page 11 residents/staff." On 11/02/20 at 4:40pm, surveyor spoke with the Risk Management/QA staff member who stated employee COVID-19 testing is set up for every Monday and Thursday from 1:00pm until 3:00pm. A roster of employees who did not come for testing is sent to the employee's supervisor and the supervisor is then responsible for ensuring the employee is tested. Risk Management/QA staff member was unable to locate any additional test results for CNA #1 and stated the CNA must have been deficient. No further information regarding this issue was presented to the surveyor prior to the remote exit conference on 11/05/20.	F 886		