STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING _____ B. WING _____	**09/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and in the course of a complaint investigation, it was determined that the facility failed to implement measures to prevent the spread of infection in two of three facility resident shower rooms, the dementia unit shower room and the COVID-19 (1) positive shower room. In both shower rooms, the facility failed to collect multiple bags of dirty laundry and linen, as well as multiple bags of trash. Both shower rooms were littered with these bags of dirty laundry and trash. The findings include: On 9/15/2020 at 11:38 a.m., the surveyor asked LPN (licensed practical nurse) #1 to accompany her to the dementia unit shower room. LPN #1 opened the locked shower room door, and the surveyor observed the floor area closest to the door littered with multiple bags of soiled resident laundry and linens, and multiple bags of trash. The surveyor and LPN #1 counted a total of 14 bags of laundry; some bags were securely fastened, and others were open, with dirty laundry/linens spilling out onto the floor of the shower room. Three plastic clothes hampers stood against the wall; each hamper was overloaded with dirty laundry, and the laundry was spilling out of each hamper. Observation revealed one securely tied industrial size black bag of resident trash on the floor. When asked about this observation, LPN #1 stated, It is like we are on the other side of the world over here. LPN #1 stated the dementia unit had not had any COVID-19 positive residents or staff, and the staff was working hard to continue this trend. When asked what is supposed to happen with dirty laundry and trash, LPN #1 stated, We are not sure what to do. This trash is still here from breakfast. She stated the facility's laundry supervisor was new to the job, and she neither knew the supervisor's name or how to get in touch with her by phone. LPN #1 stated, I don't really know what to do. This is all so new. When asked how long the laundry had been piling up, LPN #1 stated, At least the weekend. LPN #1 stated residents did regularly receive showers in the shower room. On 9/15/2020 at 11:43 a.m., OSM (other staff member) #1, a housekeeping floor technician, pushed a large cart, covered with a sheet, onto the unit. He stated he had arrived to pick up the trash. He went into the shower room. At 9/15/2020 at 11:52 a.m., OSM #2 (the housekeeping supervisor) arrived on the unit, after being called by LPN #1. OSM #2 accompanied the surveyor to the shower room. OSM #1 was standing in the shower room with the cart. OSM #2 stated the shower room floor should never be littered like it currently was. She stated that, as far as she knew, the floor technician should make rounds at least once in the morning and once every afternoon. OSM #1 stated, I was here yesterday around 1 pm. OSM #2 stated, We always put the dirty laundry in the clean shower rooms all over the building. It's not how I would do it. She stated this was not a sanitary practice. When asked what made this practice unsanitary, she stated the unbagged laundry and trash was a potential for the spread of infection. On 9/15/2020 at 12:40 p.m., LPN #2 accompanied the surveyor to the shower room on the COVID-19 positive unit. The surveyor observed multiple bags of laundry and trash scattered on the floor of the shower room. LPN #2 and the surveyor counted 14 bags of laundry (some secure and some open with laundry spilling out) and eight secured bags of trash. LPN #2 stated they usually only pick up trash and linens once a day. She further stated the shower room appeared as though nothing had been collected for several days. She stated residents on the COVID-19 positive unit usually only get bed baths. On 9/15/2020 at 12:52 p.m., ASM (administrative staff member) #1, the interim director of nursing, and ASM #2, the assistant director of nursing, were informed of these concerns. ASM #2 stated there are linen and trash bins in each of the facility's shower rooms. She stated it is someone from housekeeping's responsibility to collect the laundry and trash bags. She stated she thought the housekeeping staff collected the bags a couple of times a day. She stated the facility does not have soiled utility rooms. A review of the facility policy Collection of soiled linen and trash revealed, in part: Collection of Soiled Linen and Trash .Soiled Linen and trash containers or barrels should be on each nursing unit stored in a soiled area .These containers should be checked at regular intervals to keep the soiled linen/trash from overflowing, which may cause odor and infection control problems. Regularly scheduled pickups should be coordinated with nursing to get soiled linen off the units. No further information was provided prior to exit. References: (1) Coronaviruses are a large family of viruses found in many different species of animals, including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the outbreak of respiratory illness in people first detected in Wuhan, China, has been named [DIAGNOSES REDACTED]CoV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by [DIAGNOSES REDACTED]-CoV-2 has been named COVID-19. This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments Complaint Deficiency

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.