STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. BUILDING _____ B. WING _____	06/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to implement infection control practice to prevent the spread of infection and communicable disease during a COVID-19 outbreak on one of two units in the facility, the Linden unit. They facility staff failed to wear the correct PPE (personal protective equipment) and failed to change gloves between residents when distributing lunch trays to both COVID postive and negative residents on the Linden unit. The findings include: On 6/8/2020 at 10:00 a.m., entrance to the facility was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 informed the surveyor that rooms with pink stickers on the door indicated that the resident was positive for COVID-19, and that the rooms with a green sticker on the door indicated that the resident was negative for COVID-19. On 6/8/2020 at 12:01 p.m., CNA (certified nursing assistant) #1 was observed pushing a cart containing resident meal trays onto the Linden unit. CNA #1 put on a yellow isolation gown and gloves; he was already was wearing a mask. He took a lunch tray into room [ROOM NUMBER]. Without changing gloves or sanitizing his hands, CNA #1 left room [ROOM NUMBER], picked up another tray from the cart and entered room [ROOM NUMBER]. The pink sticker on the door indicated that the resident in room [ROOM NUMBER] was positive for COVID-19. CNA #1 did not put on a second isolation gown when he entered room [ROOM NUMBER]. While in room [ROOM NUMBER], observation revealed CNA #1's yellow isolation gown in contact with the resident's overbed table. Further observation revealed CNA #1 assisting another staff member with pulling the resident up in bed. Before he left room [ROOM NUMBER], CNA #1 changed his gloves and sanitized his hands. He did not change gowns. CNA #1 returned to the cart and picked up another lunch tray. He went into room [ROOM NUMBER]. The green sticker on the door indicated the resident in room [ROOM NUMBER] was negative for COVID-19. While in room [ROOM NUMBER], observation revealed CNA #1 touched the resident's wheelchair and overbed table, and his yellow gown was in contact with both objects. Without changing gloves or sanitizing his hands, CNA #1 obtained another lunch tray from the cart and entered room [ROOM NUMBER]. room [ROOM NUMBER] had a green sticker on the door. CNA #1's gown and gloves touched the resident's bed as CNA #1 put the tray on the overbed table and leaned over to help re-position the resident. CNA #1 removed his gloves and sanitized his hands; he did not change his gown. He obtained a new lunch tray and went into room [ROOM NUMBER], which had a pink sticker on the door, indicating the resident was positive for COVID-19. CNA #1 placed the lunch tray on the overbed table, and then leaned against the resident's bed and blankets, touching the resident's pillows. CNA #1 then removed his gloves and sanitized his hands. On 6/8/2020 at 12:25 p.m., CNA #1 was interviewed. When asked what should happen with PPE after coming in contact with a resident who is positive for COVID-19, CNA #1 stated, I'm just passing out lunch trays. On 6/8/2020 at 12:29 p.m., CNA #2 was observed going into room [ROOM NUMBER] to deliver a lunch tray. room [ROOM NUMBER] had a pink sticker on the door, indicating the resident was positive for COVID-19. She was wearing a gown, gloves, and mask. She placed the resident's lunch tray on the overbed table. CNA #2 leaned against the resident's bed as she assisted the resident with using her bed controls. She touched the resident's blankets and some of the resident's belongings. When she left the room, she did not remove her gown. She changed her gloves and sanitized her hands. She then went into room [ROOM NUMBER] to assist the resident with eating. The door to room [ROOM NUMBER] had a pink sticker on it. On 6/8/2020 at 12:38 p.m., CNA #2 was interviewed. When asked should happen with PPE after contact with a resident who is positive for COVID-19, CNA #2 stated that when she is passing the lunch trays out, she is not handling the patient, and did not have to change her gown. On 6/8/2020 at 12:41 p.m., ASM #1 and ASM #2 were informed of these concerns. ASM #2 was asked about the process staff followed regarding PPE contact with items and surface in a COVID-19 positive resident room such as bed linens, overbed table, or belongings. ASM #2 stated, They should be wearing full PPE. She stated full PPE included a gown, gloves, and mask. She stated the gloves should be removed and hands sanitized, and that the gown should be removed after coming into contact with a resident who is positive for COVID-19. A review of the facility policy, COVID-19 Isolation - Initiating Contact/Droplet Precautions, revealed, in part: Gloves will be worn (clean, non-sterile) when entering the room. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). Gloves will be removed and hand hygiene performed before leaving the room. Staff will avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. A disposable gown will be donned upon entering the room and removed before leaving the room. Avoid touching potentially contaminated surfaces with clothing after gown is removed. 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 (2) PPE: Personal protective equipment is special equipment you wear to create a barrier between you and germs. This barrier reduces the chance of touching, being exposed to, and spreading germs. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/ 7.htm

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.