STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	**06/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETH SHOLOM HOME OF EASTERN VI	**6401 AUBURN DR VIRGINIA BEACH, VA 23464**

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, and facility document review, it was determined that facility staff failed to follow infection control practices by inappropriately donning (applying) and doffing (removing) PPE (personal protective equipment) in the correct sequential order; and failed to follow infection control practices for two of two residents in the survey sample, Resident #1 and Resident #2. The findings included; Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #1's most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 4/8/20. Resident #1 was coded as being moderately impaired in the ability to make daily decisions on the Staff Assessment for Mental Status exam. On 6/25/20 at 7:31 a.m., an observation was conducted on the 400 hallway (Non-COVID Unit). At 7:33 a.m. Resident #1's room was observed. A person wearing a green uniform was observed sitting in a chair approximately three feet from Resident #1. This person had a facemask positioned underneath her chin. On 6/25/20 at 8:46 a.m., an interview was conducted with the above person. When asked her role at the facility, OSM (other staff member) #1, stated that she was a private sitter. When asked if she had her face mask on earlier, OSM #1 stated that her face mask was on half way. When asked how far away do you have to be from a resident if you do not have a face mask on correctly, OSM #1 stated that she should be six feet away. When asked if she was six feet away from Resident #1, OSM #1 stated that she was not. When asked if she should have had her face mask on properly, OSM #1 stated that she should have. On 6/25/20 at 8:50 a.m., an observation was conducted of the quarantine unit specifically the hallway for admissions/readmissions only. There were no positive COVID-19 cases on that hallway. At 8:52 a.m. CNA (certified nursing assistant) #1 was observed donning PPE (personal protective equipment) prior to entering a room on droplet precautions. The CNA had her surgical mask already in place. The CNA then put on her gloves then gown and entered the room. At 8:53 a.m., CNA #1 removed her gown and gloves together, then took off her face mask, and then went to the PPE cart outside of the resident's room and reached her hand into the box of new face masks and removed a clean face mask. CNA #1 did not sanitize or wash her hands after removing her gloves and before going the clean box of face masks. CNA #1 was then observed to walk down the hallway and sanitized hands using the free standing hand sanitizer stand in the hallway. On 6/25/20 at 8:56 a.m., an interview was conducted with CNA #1. When asked the sequence to remove PPE, CNA #1 stated that she should take off her gloves, gown and then mask. When asked what should be done after removing gloves, CNA #1 stated that she should wash her hands. When asked if the CNA did that, CNA #1 stated that she couldn't go back in the resident's room to wash her hands with soap and water once her PPE was removed. When asked if she should have sanitized her hands prior to removing her mask and prior to getting a new mask, CNA #1 did not say anything. When asked if she could have contaminated the new box of masks, CNA #1 stated, Yes. On 6/25/20 at 9:03 a.m., an observation was made on the 100 hall unit (recovery unit) At 9:04 a.m., CNA #2 was observed already to have her mask on. CNA #2 then stopped in front of a resident's room who was on droplet precautions, donned her gloves first, then her gown, and went into the resident's room. At 9:06 a.m., CNA #2 was observed doffing her PPE appropriately. On 6/25/20 at 9:06 a.m. an interview was conducted with CNA #2. When asked if she was educated on the proper donning of PPE, CNA #2 stated that she was. When asked the proper sequence of applying PPE, CNA #2 stated that she would already have her face mask on, then she should first apply gloves, and then her gown. On 6/25/20 at 9:15 a.m. signage/education in front of the 101-112 hallway documented in part, the following: Donning: gather PPE; perform hand hygiene using hand sanitizer, gown, respirator or mask .perform hand hygiene gloves .Doffing: Gloves, gown, healthcare may now exit room, perform hand hygiene . respirator and mask. Do not touch front of respirator or mask, hand hygiene . On 6/25/20 at 9:16 a.m. observations were conducted on hallway 101-112 (Hot Spot) unit. At 9:18 a.m., CNA #3 was observed in front a resident's doorway donning PPE (non-COVID positive resident but on droplet precautions). CNA #3 already had her facemask in place. CNA #3 then applied her gloves and then gown and walked into the resident's room. On 6/25/20 at 9:19 a.m., CNA #3 was observed in the doorway of a resident's room doffing PPE. CNA #3 was observed removing her gloves, then her gown, she then hung up her gown, took off her face mask and threw it away. CNA #3 exited the room and then sanitized her hands. CNA #3 then put on a new surgical face mask. CNA #3 did not sanitize or wash her hands prior to removing her facemask and exiting the room. On 6/25/20 at 9:20 a.m., an interview was conducted with CNA #3. When asked the process for donning PPE, CNA #3 stated that she should put on her gown, gloves, and that she would already have her facemask on. CNA #3 was told about the above observations. When asked if that was proper sequence of donning PPE; CNA #3 stated, Well is it? CNA #3 was told again about the above observations and CNA #3 stated, Oh. CNA #3 then stated that the resident she was working with was on droplet precautions because she came back from an operation. CNA #3 stated that the resident was not COVID-positive. On 6/25/20 at 9:32 a.m., a family member was observed in a resident's room that was on the Hot Unit. This resident will be identified as Resident #2. Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident #2's most recent MDS (minimum data set) assessment was a five day scheduled assessment with an ARD (assessment reference date) of 6/1/2020. Resident #2 was coded as being moderately impaired in the ability to make daily decisions scoring 11 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. On 6/25/20 at 9:32 a.m., Resident #2's family member was observed in his room applying foot pedals to his wheelchair. She was then observed removing items off his bedside table. Resident #2's family member had on a surgical mask only. On 9:32 a.m., an interview was conducted with the family member. Resident #2's family member stated that normally private sitters were in the room with him because he had frequent falls. Resident #2's family member stated that she sometimes helped with watching Resident #2. Review of Resident #2's June 2020 POS (Physician order [REDACTED]. This order was initiated on 6/7/20. On 6/25/20 at 10:03 a.m., an interview was conducted with ASM (administrative staff member) #1, the Administrator and ASM #2 the DON (Director of Nursing). When asked about Resident #2's diagnosis, ASM #1 stated that Resident #2 had completed his 14 day quarantine observation since being admitted back to the facility. ASM #1 stated that he was waiting to go into another room (the recovery side) of the quarantine unit. When asked if the family member had been educated on COVID-19 and the proper PPE to don while in the resident's room, ASM #2 stated that she had. When asked what PPE should be worn while caring for Resident #2, ASM #2 stated, She should wear a facemask, gowns and gloves like everyone else. ASM #1 and #2 were made aware of Resident #2's family member only wearing a surgical mask while in his room. ASM #1 stated that Resident #2's daughter would be re-educated on proper PPE. When asked the ASM #2 if the private sitter for Resident #1 had been educated on proper PPE, ASM #2 stated, Yes. The above observations were shared with ASM #1 and ASM #2. ASM #2 stated, Everyone is given a facemask when they enter the building and educated to wear. We will re-educate. When asked what her expectations are, ASM stated, I expect everyone to wear a facemask at all times to protect our residents. Also stated was, We will re-educate the sitter and provide equipment and call the family and let them know she was re-educated. The observation of the facility staff not donning and doffing appropriately was also reviewed with ASM #1 and ASM #2. ASM #1 was made aware that only two hand sanitizers were observed in the hallway as well as three isolation bins on each hallway. ASM #1 stated, We will reassess and have hand sanitizers appropriately placed at all doors on the warm and hot units and have isolation bins at each room. ASM then stated, We will re-educate all staff- nursing staff and housekeeping on new process and adding

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. BUILDING _____ B. WING _____	**06/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETH SHOLOM HOME OF EASTERN VI	**6401 AUBURN DR VIRGINIA BEACH, VA 23464**

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	(continued... from page 1) to Policy and Procedures. ASM #2 stated, We will re-educate staff on Donning and Doffing PPE. On 6/25/20 at 2:30 p.m., ASM #1 provided evidence that all four staff members were educated on hand hygiene and proper PPE use. Facility policy titled, Handwashing Policy, documents in part, the following: .5. Use alcohol based hand rub; or alternatively soap and water for the following situations .m. after removing gloves .after removing and disposing personal protective equipment.