STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DOCKSIDE HEALTH & REHAB CENTER	**74 MIZPAH ROAD LOCUST HILL, VA 23092**

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, interview and facility documentation the facility staff failed to establish and maintain infection prevention and control program for 3 of 12 residents (Residents 6, 9, and 10). The Findings include: 1) For the Kitchen, the facility staff failed to wear masks appropriately to cover mouth and nose. 2) For the COVID positive unit, the facility staff failed to have a dedicated area to don and doff PPE and dispose of PPE at entrance points to the unit. 3) For Residents 6, 9, and 10, the facility staff failed to change PPE when going from a known COVID Positive resident room to COVID Status unknown resident room. 1) On 8/11/20 at approximately 10:35 AM an interview with the Director of dietary services revealed that staff are to wear gloves and masks that cover nose and mouth, while in food prep area. On 8/11/20 at approximately 10:37 AM, Employee C (a cook in the kitchen) was walking through the kitchen wearing her mask below her nose. When asked why she was wearing it that way she stated It keeps slipping. 2) To access the Hot Zone (COVID Positive unit), Surveyor A was escorted by a Corporate Nurse, out of the building and around to the door marked Ambulance Use Only, and entered the COVID positive unit from the outside as opposed to walking through the Plastic Zippered Sheeting area dividing the halls inside. Upon entering the COVID positive unit from the outside of the building at 10:40 AM the surveyor observed there was no donning and doffing station and no trash can. The Corporate Nurse Escort (Employee E), had to step into the building and go down the hall to obtain an N-95 mask and appropriate PPE. While walking up the hall it was observed that room [ROOM NUMBER] had a gown hanging over the top of the door. The gown was hanging half in the hallway and half in the Resident room. ADON (employee B) was on the unit was asked about the gown hanging over the door and she responded, I do not know why this is here and I cannot tell if it is dirty or clean. No this should not be here I will get rid of it now. On 8/11/20 at approximately 10:55 AM while preparing to exit the building (through the day room exit onto the Patio), the Corporate RN was asked about there being no donning and doffing station set up by either of the entrances to the Unit. When asked how the staff are supposed to don and doff with no trash can or PPE she stated they usually have a trash can here. The Corporate RN stated should have an area by the exit where staff can don and doff PPE as they are entering and coming onto the unit. On 8/11/20 at approximately 1:00 PM CNA A was interviewed and she stated that she worked both units the COVID side and the other side depending on where I am needed most. When asked the normal procedure for leaving the building for breaks or lunch, she stated that You are supposed to you wash your hands and take off PPE when you leave and wash your hands and put on fresh PPE when you come back. 3) Upon walking to the other hall it was observed that 6 rooms 412-417 (total of 10 Residents), had plastic sheeting up covering the doorway. At approximately 10:50 CNA C was interviewed and she identified herself as Agency Staff and stated that she had been told the rooms at the end of the hall with the plastic are Not Positive. At 10:52 AM an interview with the Corporate Nurse and the ADON was conducted and they stated the rooms at the end of the hall are residents who were tested but before the results came back, they began having symptoms. They were left in their rooms and re-tested . On 8/11/20 at approximately 1:05 PM CNA D was observed going from food cart in hallway dressed in PPE with gloves, gown and mask to room [ROOM NUMBER] (a known positive Resident) to assist CNA C with repositioning a Resident in the bed. She exited the room with the same gloves and gown, walked to the food cart, picked up a meal tray and continued into the room [ROOM NUMBER] (COVID Status unknown) she exited the room after 4 minutes, again wearing the same PPE, and entered room [ROOM NUMBER] (COVID Status unknown), she exited that room after 2 minutes wearing the same gown and gloves. She then came back to the cart and got another tray and went down the hall to another room without changing PPE. On 8/11/20 at approximately 1:15 PM an interview with the ADON was conducted. When asked what should CNA D be when going from known positive rooms to unknown status rooms, she stated that the CNA should be changing PPE when leaving known COVID positive room to unknown status. On 8/12/20 during the end of day conference the Administrator was made aware of the issues with infection control no further information was provided.

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.