STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GARDENS AT WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

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 observations, resident interview, and staff interviews the facility's staff failed to ensure infections control measures were consistently implemented to prevent the development and/or transmission of a communicable disease (COVID-19), and other infectious diseases for nine of nine residents (Residents #1, #2, #3, #4, #5, #6, #7, #8 and #9), in the survey sample. Four resident (Residents #1, #3, #8 and #9), were not wearing a facial covering/mask while in common areas. Seven residents were not physically distanced while leisurely sitting (Residents #2, #3, #4, #5, #6, and #7) and 15 residents were not physically distanced for the noonday meal on one of three units. Two team members were not utilizing personal protective equipment (PPE) while within three feet of residents. One resident (Resident #9) was to remain isolated but was observed seated in the corridor without a facial covering on appropriately. And documentation demonstrating that one team member on duty 8/3/20, completed the screening process prior to interacting with residents wasn't available. The findings included; 1. On 8/3/20 at approximately 12:05 p.m., Resident #1 was observed sitting at a table near his room. The resident had no facial covering on but a mask was observed on the table. Resident #1 stated he was waiting for lunch to be served for he eats his lunch in that area daily. While talking with the resident two team members passed but neither directed the resident to don the facial covering. Certified Nursing Assistant (CNA) #1 was asked if there was a reason for Resident #1 not to wear a mask. CNA #1 stated she would assist the resident with the mask and did. Resident #1 was observed again at approximately 12:35 p.m., still wearing the mask. 2. On 8/3/20 at approximately 12:08 p.m., Resident #2 and Resident #3 were observed seated adjacent the nurse's station in recliner chairs and CNA #2 was observed seated between them (each chair was inches from the next). Resident #2's meal tray arrived and CNA #2 removed the facial covering and began to assist the resident with meal consumption. Resident #3 was not consuming a meal but removed the facial covering and asked if she could have assistance to put it back on. Resident #3 was assisted to don the facial covering multiple times after removing it repeatedly then asking for assistance to replace it. CNA #1 stated Resident #3 gets lonely in her room therefore she is positioned at the nurse's station area for socialization whenever she's not engaged in activity by the activity team. Review of Resident #3's documentation didn't reveal a behavior of removing the facial covering. 3. On 8/3/20 at approximately 12:12 p.m., one Broda chair and six geri-chairs were lined up side by side (no room for an individual to stand between any) in the solarium area. No resident was seated in chair #1, the Broda chair, Resident #4 was observed lying sideways in the second chair sleeping, with a leg in the Broda chair, Resident #5 was in the the third chair asleep, the fourth chair was vacant, Resident #6 was in the fifth chair asleep and Resident #7 was assisted from chair #6 to a table in the dining area. Licensed Practical Nurse (LPN) #1 was asked if there was a rationale for the positioning of the seven chairs, she stated I don't know, I'll get back to you. In the dining room of this unit was a rectangular table which could seat ten residents (4 side by side on each side) and one at the head of the table distal to the rooms entrance, preventing physical distancing of 6 feet. No resident was seated at the head of the table closest to the entrance. At the back wall were two square tables which could seat three residents for the fourth seat was against the wall, one resident was seated at these tables. Two tables were at the garden patio area window (to the right when entering the dining area); the two tables could seat three, two residents were seated at the table preventing six feet of physical distancing. And there was a table for three next to a large file cabinet, two residents were also seated at this table, preventing distancing of 6 feet. An interview was conducted with LPN #2 on 8/3/20, at approximately 12:30 p.m. LPN #2 stated each resident in the geri-chair and Broda chair area was capable of walking and they put themselves in these chairs. LPN #2 stated they hadn't attempted to rearrange the chairs to encourage physical distancing and neither was a plan developed to ensure the residents were physically distanced during meals. LPN #2 further stated the same twenty-five residents had been on the unit and each continues to test negative for COVID-19 inspite of the close contact with each other. 4. On 8/3/20 at approximately 12:35 p.m., Resident #8 was observed self-propelling a wheel chair in the corridor of room [ROOM NUMBER]. The resident had no facial covering on. He stated he needed ice and no staff was available to help him therefore he had to go get it, while still propelling his chair. Two team member passed the resident in the corridor but neither addressed he was not utilizing a facial covering. When the resident was returning to his room with the cup of ice he was wearing a mask and one of the team member who had passed the resident earlier in the corridor was behind the resident. An interview was conducted with Physical Therapy Assistant (PTA) #1 on 8/3/20, at approximately 12:38 p.m. PTA #1 stated she recognized the resident wasn't wearing a facial covering when he arrived to the nurse's station for ice and she assisted the resident to remove the facial covering from his pocket and don it appropriately. 5. On 8/3/20 at approximately 12:45 p.m., on the room [ROOM NUMBER] corridor was a Dietary team member who was observed with only a facial covering on while a therapist was walking a resident in the same direction in the corridor. Dietary team member #2 passed by the resident and the therapist and proceeded to the nurse's station with multiple single serve fruit cups in her hand. An interview was conducted with Dietary team member #2 on 8/3/20 at approximately 12:49 p.m. Dietary team member #2 stated she was only wearing a mask and not a shield or goggles because there were no active COVID-19 cases on the unit. At 12:57 p.m., Dietary team member #3 was observed on the 300 unit picking up resident meal trays after the noontime meal. Dietary team member #3 was wearing a facial covering but didn't have on goggles or a shield when she entered room [ROOM NUMBER] and came out with the resident's tray. RN #1 spoke with Dietary team member #3 after she exited the room with the tray; she stated she had her goggles in her pocket and forgot to put them on. She donned the goggles and proceeded to obtain the remaining trays. An interview was conducted with Registered Nurse (RN) #1 on 8/3/20, at approximately 12:52 p.m. RN #1 stated all staff are required to wear a shield or goggles if they will come within three feet of a resident. 6. On 8/3/20 at approximately 1:25 p.m., Resident #9 was observed sitting in the corridor across from her room. The resident had a facial covering around her neck but her mouth and nose was uncovered. Resident #9 stated she was sitting in corridor waiting for the environmental staff to finish mopping her floor and the floor dries. Resident #9 stated she was no longer capable of mopping her own floors. While Resident #9 was sharing the above information LPN #4 approached the resident, pulled her mask up over her mouth and nose and told the environmental staff that the resident shouldn't be out of her room and next time they need to mop around the resident. LPN #4 put the resident inside the room and closed the door. Resident #9's Nurse Practitioner progress note dated 7/28/20, stated the resident tested positive for COVID-19 on 7/9/20 and after the initial fever she had remained stable. The resident has a history of [MEDICAL CONDITIONS] and at her baseline requires supplemental oxygen . She meets clinical criteria to be cleared but will remain isolated with regular health monitoring. The above information was shared with the Administrator, Director of Nursing and the Assistant Director of Nursing on 8/4/20 at approximately 10:05 a.m. The Administrator directed a review of the facility's Infection Control Policy and Procedure: Novel Coronaviruses dated 3/10/20. Under Resident Surveillance #4 the policy read: If they leave their room , residents should wear a cloth face covering, perform hand hygiene, limit their movement in the facility and perform social distancing (stay 6 feet away from others). Under Staff Member surveillance the policy read at #6: Universal masking will be followed for all staff working in the facility. #7; Eye protection (for example, face shields or goggles) will be worn by any staff with resident contact

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) (i.e. within 3 feet). Under Staff Member surveillance the policy read at B1: All staff members will be screened and have temperatures checked by staff posted at each designated Staff member area prior to staring their shift. B2 reads; Staff member sign in log will be maintained at each designated area for surveillance and tracking. A designated Staff member will log screening responses and temperature readings prior to beginning work. 7. On 8/5/20 a review was completed of the 8/3/20 team members screenings for those working the day shift. The review revealed one staff member LPN #5 worked on the day shift on 8/3/20, but no screening documentation was available to demonstrate the screening was conducted. An interview was conducted with the Administrator via telephone on 8/6/20 at approximately 11:30 a.m. The Administrator stated I was not able to locate a recorded screening for (name of the team member). I interviewed her and she verbally confirmed that she was screened Monday but I was not able to locate a log with this information.