STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495155	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANNANDALE HEALTHCARE CENTER	**6700 COLUMBIA PIKE ANNANDALE, VA 22003**

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.** Based on observations, staff and resident interviews and facility documentation, the facility staff failed to ensure infection control measures were consistently implemented to prevent the development of transmission of a communicable disease (COVID-19). Specifically, the facility staff failed to maintain physical distancing during the screening process and while on the elevator to prevent the possible transmission of infection; failed to follow the facility's screening process to include temperature checks and questions related to COVID-19 exposure or symptoms; and failed to to perform appropriate hand hygiene. The findings include: 1. The facility staff failed to maintain physical distancing during the screening process and while on the elevator to prevent the possible transmission of infection. On 7/22/20 from 6:43 a.m. to 7:20 a.m., Registered Nurse (RN) #1 was observed screening the oncoming 7 a.m. to 3 p.m. staff. Although there were large round red signs plastered on the side walk leading into the outer door of the facility, in the vestibule area between the outer and inner door, as well as on the floor in the lobby that denoted 6 foot areas to position themselves, the staff were not adhering to the signs. Staff grouped up in the vestibule waiting to be buzzed in by RN #1. She consistently redirected most of the staff to back out of the vestibule to allow 6 feet physical distance in order to buzz in and permit one staff to enter the lobby. As staff entered the lobby, the RN kept directing the staff to stand on the 6-feet signs and marking on the floor to maintain the required physical distance. On 7/22/20 at 7:10 a.m., a refrigerator repair vendor entered the vestibule with two other persons and once RN #1 buzzed in an oncoming staff, with no regard for maintaining physical distance or his natural place in line outside on the sidewalk, he came in with an oncoming staff, approached the front reception desk beside the another staff and stated, I am here about that refrigerator. The RN was in the process of taking an infrared temperature of the staff in line, but immediately obtained the vender's temperature, essentially screening two persons at the same time. During aforementioned observations of the screening process, more than two employees would board the elevators. The RN was observed perspiring as she stated, I try to do the best I can to control and redirect staff, but I can't always catch everything. There were clear signs on the outside of the elevator that instructed no more than two people per ride in order to maintain 6-feet physical distance. When this surveyor was standing at the elevator door to board it, an employee with a resident in the wheelchair turned and stated, You can come on with us, we don't count two persons per ride when we have a resident with us. The surveyor did not board the elevator which would have placed three persons at less than 6-foot range. 2. The facility staff failed to follow the facility's screening process to include temperature checks and questions related to COVID-19 exposure or symptoms in order allow safe entry to protect staff and residents from potential transmission of infection. The receptionist had taken over the screening process on 7/22/20 at 8:00 a.m. At 8:20 a.m., the receptionist received a buzzer notification from outside of the kitchen back door, which initiated viewing the person over the monitor. The person at the door was the milk delivery distributor requesting entry into the kitchen. The receptionist told him he needed to ride around to the front lobby to screen in and then drive back around to be buzzed in. She stated she was the only one that had the code in order to open the kitchen's back door. She said the milk delivery distributor said he had already been in the kitchen earlier, so the receptionist called the kitchen to inform the kitchen staff that milk delivery distributor wanted entry into the kitchen. The receptionist said she was told to let him in, which she did. She turned to this writer and said, I shouldn't have done that but I thought that person that told me to let him in had more authority than me. She said I called to inform the Administrator. On 7/22/20 at 8:35 a.m., this surveyor went to the kitchen and upon entering spoke to Dietary Staff #1. He stated, He was here earlier, so I told her to let him in. A second Dietary Staff #2 verified that the milk delivery man had been in the kitchen earlier, brought a cart into the walk-in refrigerator and delivered milk, but came back around 8:15 a.m. to take the milk back that he had delivered earlier. Dietary Staff #2 said, He came in again with his cart, into the refrigerator and took back 100 cartons of whole milk, stating he brought too much earlier and needed to take it back. He also stated the Assistant Administrator had just left to screen the milk delivery distributor out. When asked how he got into the kitchen earlier, he stated, Maybe through the door where we take out the trash, but he should not have come in that way and not before he went up to the front to be screened. On 7/22/20 at 9:00 a.m., the staff surveillance line listing was reviewed to determine if the milk delivery distributor had screened in earlier. There was only one recent entry with no time that indicated Milk Delivery Guy (no location) 97.7 temperature, no cough and no shortness of breath. The receptionist stated the Assistant Administrator screened the milk delivery man as he was leaving the kitchen around 8:30 a.m. on 7/22/20 and called her to write in the information on the staff surveillance line listing form. 3. The facility staff failed to to perform appropriate hand hygiene in accordance with the Centers for Disease Control and Prevention (CDC) guidelines and the facility's policy and procedure for standard precautions. On 7/22/20 at 9:20 a.m., Housekeeper #1 was observed on West I removing trash from resident rooms using her bare hands to press trash down into plastic bags. Afterwards, she then tied up and transported the bagged trash to the biohazard room. The housekeeper walked off the unit to the basement. Although there were no COVID-19 cases on WEST I, the housekeeper failed to wear gloves while handling trash and or wash her hands after removing trash from individual room, as well as after disposal of trash in the biohazard room. On 7/22/20 at 11:50 a.m., an end of day debriefing was conducted with the Administrator, Assistant Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). They stated they would find out what happened with the milk delivery situation. The DON stated that the milk delivery man should not have taken milk back because they may have been able to use it on the units. The Assistant Administrator stated more re-training would take place with the vendors. The DON stated hand washing and the use of alcohol based hand rub had been a focus with all staff, but re-training would be conducted with the housekeeping staff. On 7/23/20 at 11:39 a.m., a phone interview was conducted with the Food Service Manager (FSM). She stated she was not present in the kitchen when the milk delivery distributor entered the kitchen and he should have never come in with a cart and entered the walk-in refrigerator. She stated he should have rung the buzzer, have the front desk allow the door to be opened and the milk taken from him. She stated he should have never been allowed to come in a second time either, enter the refrigerator with his cart and take back milk. She also stated only the front desk had the code and ability to allow entry from the kitchen's back door, but exit is possible when they take the trash out from the kitchen and maybe that was how he was able to gain entry the first time. The FSM said, My people know what to do, they have been trained, but more training will take place. All persons, to include vendors, must stop up front first for the initial screening, then come to the kitchen back door where we will take the product from the vendors. I am also concerned about where he took that milk to. I have had serious conversation with the company where we obtain our milk supply. The nursing facility's COVID-19 plan incorporated visitor and employee screening dated 3/5/20. The screening included temperature checks and questions at the start and end of shift, as well as symptoms of a cough and/or shortness of breath. The COVID-19 plan updated 4/8/20 included if the temperature was identified (100.4 per CDC), that person would be asked to return home. All staff would be entering and exiting the building through the front lobby. The nursing facility's all staff in-services on COVID plan dated 3/6/20 and 3/7/20 included PPE usage, hand washing and respiratory droplet precautions. The training

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) incorporated the policy and procedure titled Standard Precautions dated 10/31/18 that indicated hand hygiene is a simple but effective way to prevent the spread of infections by breaking the chain of infection. Proper cleaning of hands can prevent the spread of germs and the facility will adhere to 2016 CDC guidelines. Hand hygiene included two techniques: 1. Hand washing with soap and water 20 sec; 2. Alcohol-based hand sanitizer. Hand hygiene to be performed after handling personal items and provision of care between residents, potential of exposure to patients and/or infectious materials and after glove removal. This policy applied to healthcare personnel and housekeeping (among other staff and contractual staff). Social Distancing postings (no date) at the nurse's stations and elevators indicated staff should practice social distancing and maintain 6 feet distance from each other, including in staff huddles and break rooms to help prevent transmission of COVID-19.