STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PORTSMOUTH HEALTH AND REHAB	**900 LONDON BOULEVARD PORTSMOUTH, VA 23704**

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 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 6 residents (Residents #1-#6) in the survey sample. The residents were not wearing facial coverings and/or not social distancing. Also, facility staff failed to wear facial coverings/masks appropriately, and failed to store used linen appropriately. The findings included: 1. Resident #1 was originally admitted to the facility 6/7/10 and readmitted [DATE] after an acute care hospital stay. The current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/9/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were moderately impaired. In section G (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of one person with bed mobility, transfers, toileting, and personal hygiene, and supervision of one person with eating. On 6/22/20 at approximately 2:00 p.m., Resident #1 was observed self-propelling up and down the corridor, passing by multiple staff, other residents, and the nurse's station where staff were seated. The resident was unmasked and no one intervened. The Administrator was walking along and also made the observation. The Administrator spoke with a staff member concerning the matter, shortly thereafter Resident #1 was observed self-propelling up and down the corridor with a mask on and making no attempts to remove it. Resident #1 was observed again at approximately 2:45 p.m., in the corridor with the mask still on and donned appropriately. 2. On 6/22/20 at approximately 2:20 p.m., Resident #2 and Resident #3 were observed seated outside the activity room. They were not physically six feet apart. They stated they didn't share a room but they were waiting together for activity staff to open the door so they could make snack purchases (drinks and cookies). Neither resident had been tested for COVID-19. Resident #2 was originally admitted to the facility 9/7/19 and had never been discharged from the facility. The current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/13/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were moderately impaired. In section G (Physical functioning) the resident was coded as requiring supervision of one person with wheel chair locomotion Resident #3 was originally admitted to the facility 8/15/13 and had never been discharged from the facility. The current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/16/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #3's cognitive abilities for daily decision making were intact. In section G (Physical functioning) the resident was coded as requiring supervision after set-up with wheel chair locomotion. The Administrator stated to the residents that they were too close to each other and she physically assisted Resident #2 to distance from Resident #3. The Administrator stated since they self-propel and were not in an area staff frequents, the staff likely didn't observe they were physically too close. The activity room is off a main corridor where many residents reside and in an area viewable to all walking the corridor. 3. On 6/22/20 at approximately 2:20 p.m., Certified Nursing Assistant (CNA) #1 was observed in the corridor with the mask below her nose. CNA #1 was interviewed at the time of the observation in the presence of the Administrator. CNA #1 stated It keeps sliding. CNA #1 attempted to pinch the nasal area together to aid the mask to not slide down but it didn't pinch. CNA #1 had donned the mask up side down, therefore the area with the metal clip to adjust across the bridge of the nose was beneath the chin. The Administrator stated all staff had been educated on donning a mask and education is ongoing. 4. On 6/22/20 at approximately 2:26 p.m., Certified Nursing Assistant #2 was observed in a resident room with the mask below the nose. Once CNA #2 entered the corridor an interview was conducted. CNA #2 stated the mask Won't stay up. CNA #2 attempted to adjust the mask across the nose but it came down again. Further observation revealed the mask was donned up side down with the metal adjuster beneath the chin instead of over the bridge of the nose. 5. On 6/22/20 at approximately 2:35 p.m., Environmental staff #1 was observed in the corridor with the mask beneath the nose. Environmental staff #1 stated it slides as the mask was adjusted over the nose. The mask slipped down again. Environmental staff #1 was unable to adjust the adjuster, which should have been over the bridge of the nose because the adjuster was beneath the chin. Environmental staff #1 donned the mask appropriately and pinched the adjuster to get a better fit. 6. On 6/22/20 at approximately 2:38 p.m., Resident #4 and Resident #5 were observed seated wheel chair to wheel chair together in Resident #5's room. They were talking about vacations and sharing a cruise catalog, neither resident was wearing a mask. Unit Manager #1 stated the two residents were not husband and wife and they didn't room together but they were good friends. Neither resident had been tested for COVID-19. Resident #4 was originally admitted to the facility 9/9/19 and had never been discharged from the facility. The current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/24/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #4's cognitive abilities for daily decision making were intact. Resident #5 was originally admitted to the facility 10/23/19 and had never been discharged from the facility. The current [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/30/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #5's cognitive abilities for daily decision making were moderately impaired. Unit Manager #1 donned a mask on each resident but didn't physically separate them six feet apart. Resident #4 and Resident #5 were again observed in Resident #5's room at approximately 3:03 p.m., they were still seated in the same position and wearing their masks. 7. On 6/22/20 at approximately 2:59 p.m., Resident #6 was observed on the Observation Unit. The resident was on the observation unit pending no signs and symptoms of COVID-19 for 14 days, after a hospital discharge. Resident #6 had a mask on but it was positioned below the nose and mouth. The Resident left the room and walked in the corridor to talk. The resident rambled on and on without making a sensible statement. Inside the room was a staff member identified as Resident #6's sitter to keep the resident engaged and deter wandering. The sitter didn't assist the resident to don the mask appropriately nor redirect the resident back to the room from the corridor. An interview was conducted with Sitter #1. Sitter #1 stated I try but; it doesn't work. Unit Manager #2 stated on 6/22/20 at approximately 3:45 p.m., there are items available in room to engage the resident but because the resident's attention span is very short one can only engage the resident for short periods of time. 8. On 6/22/20 at approximately 3:05 p.m., Certified Nursing Assistant #3 was observed in a resident room with a large amount of linen on the floor at the doorway. CNA #3 was interviewed while scooping the linen into a plastic bag. CNA #3 stated there was no bag present in the room therefore, the linen was left on the floor until one could be retrieved. CNA #3 further stated the Environmental staff would ensure the floor was mopped after the linen was removed. On 6/23/20 at approximately 3:30 p.m., the above findings were shared with the Administrator, two Unit Managers, Social service Director, MDS Coordinator and other staff via telephone conference. No additional information was provided related to the above observations.

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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