STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495315	A. BUILDING _____ B. WING _____	05/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONSULATE HEALTH CARE OF WOODSTOCK	803 SOUTH MAIN ST WOODSTOCK, VA 22664

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, clinical record review and facility document review, the facility staff failed to maintain infection control practices during a COVID-19 (1) outbreak in the facility, for one of six sampled residents, (Resident #4); and the staff failed to handle linens in a manner to prevent the spread of infection on one of two units, (the COVID, positive isolation unit). The facility staff failed to maintain infection control practices for the use of PPE (personal protective equipment) between multiple residents including Resident # 4 whom was diagnosed with [REDACTED]. The facility staff failed to ensure a cloth gown that was in direct contact with the facility floor on the COVID-19 positive isolation unit was not in contact with other clean gowns and not used when providing care to a resident. The findings include: 1. Resident # 4 was admitted to the facility with [DIAGNOSES REDACTED]. Resident # 4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/02/20, coded Resident # 4 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 4 was coded as requiring extensive assistance of one staff member for activities of daily living. On 5/14/20 at 3:45 p.m. an observation was made of CNA (certified nursing assistant) # 3 providing care to residents on the COVID-19 isolation unit. CNA # 3 was observed in Resident # 4's room wearing an isolation gown, gloves and mask. CNA # 3 was observed taking Resident # 4's temperature and pulse oximetry (measures oxygen level) reading using a pulse oximeter, which fit onto the resident's finger. CNA # 3 was then observed leaving Resident # 4's room wearing the isolation gown, gloves and mask and going into four additional rooms performing the same procedures with the residents in those rooms. CNA # 3 failed to change gloves, wash hands or clean the equipment making contact with the residents between each resident. At 3:53 p.m., CNA # 3 was observed at the nurse's station cleaning the pulse oximeter and the thermometer after completing the procedures with the five residents observed. A laboratory report dated 03/07/2020 for Resident # 4 from (Name of Hospital) documented in part, 03/08/2020. Positive for Toxigenic [DIAGNOSES REDACTED]icile. The Physician's Telephone Order, dated 03/10/2020 for Resident # 4 documented, [MEDICATION NAME] 125mg (milligrams po (by mouth) daily x (times 7 (seven) days then [MEDICATION NAME] 125mg po every 2 (two) days for 6wks (six weeks). The POS (physician's orders [REDACTED]. The comprehensive care plan for Resident # 4 dated 07/31/2019 with a revision date of 03/11/2020 documented, Focus: (Resident # 4) has [DIAGNOSES REDACTED]icile. Under Interventions, it documented in part, Disinfect equipment used before it leaves the room. Date Initiated: 07/03/2019. On 5/14/20 at 4:25 p.m., an interview was conducted with CNA # 3 about the observation of going room to room wearing an isolation gown, gloves, mask, taking temperatures and pulse oximetry readings without changing gloves or cleaning the pulse oximeter between residents. CNA # 3 stated that they went room to room and did not change gloves or wash their hands because I technically did not touch them, I just slip their finger into the pulse ox. When asked if they cleaned the machine between resident uses, CNA # 3 stated she did not see any wipes in the hall. CNA # 3 stated, I know you are supposed to do that but when you don't see them (disinfecting wipes) you can't do them. CNA # 3 stated that after she saw the wipes at the nurse's station the machine was wiped down. When asked if she was aware of any reason why it was important to change PPE after caring for Resident # 4, CNA # 3 stated, I do not have an answer for that, I do not remember anything. CNA # 3 stated, We use sanitizer to not spread the infection around but it is hard when you don't have the supplies you need. I didn't realize the wipes were there until after I finished. On 05/14/20 at 4:42 p.m., an interview was conducted with RN (registered nurse) # 1, assistant director of nursing, in the presence of OSM (other staff member) # 4, social service director, OSM # 6, human services director, OSM # 7, business development coordinator, and ASM (administrative staff member) # 5, senior regional director of operations, who on the phone. After being informed of the observation described above RN # 1 was asked to describe the procedure staff follows for a resident with [MEDICAL CONDITION]. RN # 1 stated staff should follow contact precautions, washing with soap and water, and disinfecting equipment. When asked why it was important to follow those procedures, RN # 1 stated to try to stop the spread of [MEDICAL CONDITION]. On 5/15/20 at approximately 9:10 a.m., a request was made for the facility policy on following infection control precautions for [MEDICAL CONDITION], a handwashing policy related to direct resident care and for disinfecting shared medical equipment to ASM (administrative staff member) # 3, the regional director of clinical services was made aware of the above findings by telephone. A request for Resident # 4's comprehensive care plan, the recent signed physician's orders [REDACTED].# 3. The facility's policy Standard and Transmission Based Precautions documented in part, Standard Precautions: Used for all patients It is common sense practices and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient. Hand Hygiene, Equipment and environment cleaning. Under Transmission Based Precautions, it documented in part, Transmission Based Precautions: used in conjunction with standard precautions. Patient Equipment: use disposable or dedicated patient-care equipment (If equipment is used for multiple patients, clean and disinfect prior to use on another patient). According to Gerontological Nursing, Lippincott, Williams and Wilkins Eighth Edition, page 414 documented, The spores or pathogens like [DIAGNOSES REDACTED]icile can persist on the surfaces of furniture and equipment for months and contaminate the hands of caregivers; strict adherence to handwashing procedures is crucial to protect both patients and caregivers from developing infections. According to Gerontological Nursing, Lippincott, Williams and Wilkins Eighth Edition, page 414 documented, Diarrhea and abdominal cramps are common symptoms associated with [DIAGNOSES REDACTED]icile infections .Because this infection can spread from infected fecal matter being transported by contaminated objects or hands, the use of gloves, strict handwashing techniques, cleaning of environmental surfaces (usually with a bleach solution), and use of [MEDICATION NAME] or contact precautions are crucial. According to Lippincott Nursing Procedures Seventh Edition, pages 651-653 it documented, Pulse oximetry .Completing the procedure .remove the probe, turn off and unplug the unit and, if using a reusable probe, clean it by gently rubbing it with a disinfectant wipe or pad. Perform hand hygiene. Document the procedure. On 5/15/20 at approximately 9:10 a.m., ASM # 3 stated that the facility staff follows their policies and Lippincott as their standard of practice. No further information was provided prior to exit. Reference: (1). COVID-19 is caused by a coronavirus called [DIAGNOSES REDACTED]-CoV-2. Coronaviruses are a large family of viruses that are common in people and may different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people. This occurred with MERS-CoV and [DIAGNOSES REDACTED]-CoV, and now with [MEDICAL CONDITION] that causes COVID-19. [DIAGNOSES REDACTED]-CoV-2 virus is a betacoronavirus, like MERS-CoV and [DIAGNOSES REDACTED]-CoV. All three of [MEDICAL CONDITION] have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir. However, the exact source of this virus is unknown. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads (2). [MEDICAL CONDITION] is a gram-positive anaerobic bacterium most often associated with antibiotic-associated diarrhea. Symptoms may range from asymptomatic carrier states to severe pseudomembranous [MEDICAL CONDITION] and are caused by toxins produced by the organism. Although [MEDICAL CONDITION] infection can be caused by almost any antibiotic that disrupts the intestinal flora, it's classically associated

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) with [MEDICATION NAME] use. Patients at high risk for this disorder include include those that are taking many kinds of antibiotics immunosuppressed individuals, and those in nursing homes. [MEDICAL CONDITION] may be transmitted directly from patient to patient via contaminated hands of facility personnel (most common) or indirectly through contaminated equipment such as bedpans, urinals, call bells, .and surfaces such as bedrails, floors, and toilet seats .because spores of [MEDICAL CONDITION] are resistant to most commonly used facility disinfectants the patients room may be contaminated even after the patient has been discharged . The immediate environment must be thoroughly cleaned and disinfected with 0.5% sodium hypochloride .standard precautions for contact with blood and body fluids should be used for all direct patient contact and contact with the patient's environment. Use good handwashing technique with antiseptic soap after direct contact with the patient or environment .reusable equipment must be disinfected before use on another patient or disposable equipment should be used This information was obtained from: Springhouse Handbook of Diseases- Causes, Signs and Symptoms, Patient Care- 2007 Springhouse Corporation pages 217-219 (3). A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/[MEDICAL CONDITION].html. 2. On 05/14/2020 at 4:05 p.m., CNA # 3 was observed at the clean linen laundry cart on the COVID -19 positive isolation unit. CNA #3 removed two clean gowns, and one gown fell on to the floor, CNA # 3 picked the gown up off the floor and placed it onto the cart right across from the laundry cart that contained PPE (personal protective equipment) and four clean gowns lying on top of the cart. CNA # 3 paced the gown that had fallen to the floor on top of one of the clean gowns on the cart. At approximately 4:06 p.m., an interview was conducted with RN (registered nurse) # 3. When asked about the cart in the hallway across from the clean linen cart, RN # 3 stated that it contained clean gowns that were ready to be used. On 5/14/20 at t 4:16 p.m., an observation revealed that a CNA #1 picked up a gown from the top of the cart that was in contact with the gown observed previously on the floor. CNA #1 put the gown on and went into a positive COVID-19 resident room. Then CNA # 3, who originally put the gown on cart from the floor, took that gown, put it on, and went into the resident room to assist CNA #1. Observations of the activity in the resident room revealed they repositioned the resident, folded the blankets and sheets. Further observations revealed that while the sheets and blanket were being folded they brushed up against CNA #1 and #3s gowns, and then the sheets and blanket were repositioned over the resident. On 005/14/2020 at 4:28 p.m., an interview was conducted with CNA # 3 regarding the gown that fell to the floor. When asked if a gown she had taken from the clean linen cart had fallen to the floor, CNA # 3 stated, Yeah I do, I set it on one of the little counters (top of cart). Yes, on the yellow cart. They are clean gowns on the cart. In my opinion I would say it is clean but no it's not clean. When asked if the gown that fell to the floor could contaminate other gowns on top of the cart CNA # 3 stated, It could have been. CNA #3 was asked about putting on the gown that was on the floor and going into the resident's room. CNA # 3 stated, If considering that gown, I should not have, considering this is already contaminated, limited supply of gowns, say someone coughs on your sleeve, put your arm on your chest it would be smart to take it all off but if you don't have what you need. Considering I used it, it's ok but it's not ok. If I was more aware of my surroundings then rest of the linen wouldn't have gotten contaminated. On 05/14/20 at 4:42 p.m., an interview was conducted with RN (registered nurse) # 1, assistant director of nursing, in the presence of OSM (other staff member) # 4, social service director, OSM # 6, human services director, OSM # 7, business development coordinator, and ASM (administrative staff member) # 5, senior regional director of operations, who on the phone. After being informed of the observation described above RN # 1 was asked to describe the procedure staff follows when clean linen or gowns are dropped on the floor. RN # 1 stated they should have gone into hamper to be laundered. On 5/15/20 at approximately 9:10 a.m. a request was made to ASM (administrative staff member) # 3, the regional director of clinical services was made aware of the above findings by telephone. A request for the facility policy on following infection control precautions for [MEDICAL CONDITION], a handwashing policy related to direct resident care and for disinfecting shared medical equipment, Resident # 4's comprehensive care plan, the recent signed physician's orders [REDACTED].# 3. On 5/15/20 at approximately 9:10 a.m., ASM # 3 stated that the facility staff follows their policies and Lippincott as their standard of practice. No further information was provided prior to exit.