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 _____	**05/07/2020**

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 interview, clinical record review, and facility documentation, the facility staff failed to ensure infections control measures were consistently implemented to prevent the development and/or transmission of a communicable disease (COVID-19) among staff and residents. The findings include: 1. The facility staff failed to adequately implement their planned screening process at shift change, as well as maintain social distancing, as exhibited during the following observations on 5/5/20: On 5/5/20 at 6:30 a.m., a Certified Nursing Assistant (CNA) was observed at the reception desk performing a COVID-19 self screening prior to his shift (7 AM-3 PM). He looked at this surveyor and said, Someone should be here and I don't want to wait. Why don't you do it, since you are standing here. I have to clock in! The CNA bare handedly took his temperature with the infrared thermometer, recorded his temperature as 96.6 degrees Fahrenheit (F), as well as recorded N (no) for cough and shortness of breath. On 5/5/20 from 6:45 a.m., a line began to form from the outside on the sidewalk, the outer foyer, and the lobby to the reception desk. There was no screener in place and the same questions ensued. One staff member left the line and stated, I have to clock in! I will just have to come back! There was no way to determined if he returned to be screened due to the mass amount of staff that formed outside and inside. Another staff person that was in line in the outer foyer, was heard saying, I can't do this! He left the line and headed toward his right, which would be the Emerald unit (not an assigned entry point). Others in the line started to ask, Where is the supervisor? Various staff persons started screening themselves and the one behind them. One staff person stated, This thermometer is reading 'lo'. What do we do? A second person left the line to clock in and stated stated she would come back to be screened. On 5/5/20 at 6:50 a.m., CNA #1 stated, I will get this done! and started screening staff, but had trouble operating the thermometer. Licensed Practical Nurse (LPN) #1 from the West 1 unit arrived at 6:52 a.m. with her infrared thermometer. She stated, I heard you (this surveyor) was here and there were problems with the thermometer, so I brought the one from my unit. Once she checked the infrared thermometer assigned to the reception desk, she stated, There is nothing wrong with this thermometer! All temperature readings from the infrared thermometer dedicated to screen staff and venders oncoming and exiting the facility on the 7 AM-3 PM shift evidenced readings of 96.8 (F) to 97.6 (F) on the sign in sheets. The same was true for the 3/11 and 11/7 shift temperature readings. On 5/5/20 at 6:55 a.m., Licensed Practical Nurse (LPN) #2 took over. She stated she was the wound care nurse and thought the night supervisor may have had to start an intravenous (IV) line on a resident, but there was no on else take her place. She also said the receptionist came in at 8:00 a.m. to screen all coming and going staff and or vendors. LPN #2 said the screener needed to wear a face shield and a mask and be trained on how to use the infrared thermometer and ensure surveillance form questions were appropriately answered and if there was any reason to suspect a problems that would disable them from working. She stated the form also monitored those staff leaving their shift (in this case 11 PM-7 AM) that encompassed the same questions and temperature check. LPN #2 was reminded that this surveyor had not been screened, after which screening was conducted by LPN #2. Due to number of staff waiting to be screened, they grouped up on the elevator to access the time clock which disallowed social distancing of 6 feet per signage instructions on and within the elevator. On 5/5/20 at 7:38 a.m., another nursing staff member was screened that was leaving and no further staff was observed at 7:40 a.m. LPN #1 left the reception area, but stated she had some concerns because there would be no one at the desk until 8:00 a.m. On 5/5/20 at 7:42 a.m., the 11 PM-7 AM supervisor, Registered Nurse (RN) #1 appeared and stated she was going to have a CNA (#2) monitor the desk until the receptionist came in. The wound care physician was screened by RN #1 at 7:46 a.m. CNA #2 arrived at the receptionist desk to take over any screenings at 7:48 a.m. 2. The facility staff failed to dispose of PPE to prevent possible transmission of infection and to properly store reusable personal protective equipment (PPE). On 5/5/20 at 8:00 a.m., a tour of the facility units was conducted along with RN #1. Upon entering the East Stairwell to arrive on the West 2 unit, where most of the COVID-19 residents were being transferred (information per RN#1), a blue disposable isolation gown and gloves were observed on the steps. RN #1 stated, I can't believe this and disposed of the gown and gloves. On 5/5/20 at 09:00 a.m., a wall hanging that resembled a clothes line flush against the wall was observed on every unit. The instructions indicated at end of every shift the individual staff's disinfected face shield to be placed in a 3 gallon zip locked bag and the individual N95 mask placed in a paper bag, both labeled with name and date. Several staff had placed the N95 in the plastic zip locked bag along with the face shield and/or placed the paper bagged N95 inside the zip locked bag with the face shield. West 2 Unit Manager RN#2 stated the instructions were written on two props (zip locked bag and paper bag) and at the end of the five days, both face shield and N95 would be changed out for new ones. During a conversation with the local Public Health Nurse, who was at the facility on 5/5/20 at 10:40 a.m., she stated the purpose of the N95 in a paper bag allowed for aeration so as not to harbor germs/particles, but some staff still need more education even though the example was clearly posted on the clothes line. She said the bagged N95 should not be in the zip locked bag for the same reason, and the zip locked bag was for the disinfected face shield. 3. The facility staff failed to perform appropriate hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) guidelines and the facility's policy and procedure for infection control. On 5/5/20 from 9:20 a.m. to 10:10 a.m., the housekeeper on West 2 unit was observed entering and exiting the rooms of COVID-19 positive Residents #1, #2, #3, #5, #6, #7 and #8 and COVID-19 negative Resident #4's room. The housekeeping supervisor was following along in the hallway with the West 2 housekeeper. It was stated by the housekeeping supervisor, who verbally interpreted for the West 2 housekeeper, that only trash was removed in the ward room where Resident #4, #5 and #6 resided due to Resident #4 status as COVID negative. The West 2 housekeeper also cleaned two empty rooms along the same hallway. The housekeeper did not remove gloves, perform hand hygiene and reapply gloves between rooms. The housekeeper did not go from a COVID positive to the COVID negative room. The West 2 Unit Manager RN (#2) stated it has been a challenge to ensure the housekeepers understood when to change PPE to include gloves followed by hand hygiene, preferably washing hands. The housekeeping supervisor reiterated the same protocol as the Unit Manager and stated he would watch more closely from now on. Until the remaining COVID-19 negative residents were removed off of West 2, the concern remained whether the housekeeping staff would clean a negative room from a positive room without appropriately donning and doffing PPE. Both the housekeeper and housekeeping supervisor frequently touched their faces and readjusted their face masks. On 5/5/20 at 10:40 a.m., CNA #3 was observed opening the dirty utility room and disposing of bagged dirty linen which was next to the West 2 nurse's station where this surveyor was located. The CNA proceeded down the hallway into another resident's room. CNA #3 did not perform hand hygiene before entering the resident's room. The CNA frequently touched his face shield and repositioned his N95 with his hands, with and without gloves. The local Public Health Nurse (PHN) was at the nurse's station and also observed the CNA's failure to perform hand hygiene and stated, I see he did not wash his hands. I want the staff to wash their hands when soap and water is available. This is one of the areas I continue to bring to the facility's attention. Constant staff education is necessary in this building. Although there has been improvement over the last three weeks, I have brought to their attention some observations related to social distancing, all staff wearing masks and ensuring they have their issued face shields in place. On 5/5/20 at 10:50 a.m., when asked

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) about hand hygiene, CNA #3 stated he washed his hands in the bathroom behind the nurse's station after he disposed of the linen in the dirty utility room. When told by this surveyor that he was observed also by the PHN not washing his hands, he said, But, I washed my hands one time back there (bathroom behind nurse's station). A review of the facility's policies and inservices included: 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, handwashing and respiratory droplet precautions. The training 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. Handwashing 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). The COVID-19 Checklist for Environmental Services dated 4/2/20 identified that discharge and isolation rooms are to be cleaned last. Empty trash into a double bag, disinfectant is gently poured into a cleaning cloth and surfaces wiped gently and allowed to dry completely. Correct dwell times must be used during cleaning, replace liners in room and bathroom. Proper hand hygiene before and after entering isolation rooms includes washing hands after removal of gloves and re-gloving for each subsequent rooms. The policy and procedure titled Use of PPE during the COVID-19 Pandemic dated 3/19/20 was specific for the use of PPE during the care of residents in isolation to conserve masks, face shields and gowns based on the issued guidance from CDC dated 3/18/20. The recommendations were designed to protect from droplet exposure. Face masks are to be worn by all staff. The N95 mask is to be placed in a paper sack and hung on a peg (clothes line with clothes pin in this facility's case). The eye protection/face shield is dedicated to one staff and cleaned when visibly soiled and at the end of the shift, stored appropriately. Staff must take care not to touch face mask and face shield. If they touch or adjust their facemask they must immediately perform hand hygiene. 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. On 5/5/20 at 4:40 p.m., an interview was conducted with the Director of Nursing (DON), the Administrator, the Assistant Administrator and the Regional Director of Clinical Operations (RDCO). The DON and RDCO stated it was their expectation that the staff wash their hands after removal of gloves, before and after interaction with a resident and that all staff placing either linen or trash in the dirty utility room immediately wash their hands afterwards and only use alcohol-based hand rub if no access to soap and water. The DON and RDCO stated the housekeeper should have removed her gloves, washed her hands and re-applied gloves between the cleaning of each room and or emptying of trash. They all stated there should have been a trained screener at the front reception desk at the 7-3 shift change, usually the 11-7 supervisor until the receptionist came in tat 8:00 a.m. to monitor the front desk. The Administrator stated he expected staff to practice social distancing to maintain 6 feet from each other to include congregating in the foyer, lobby and on the elevator. On 5/6/20 at 12:07 p.m., a telephone interview was conducted with the aforementioned Administrative group. They concurred that they verified with the 11-7 supervisor, RN #1 the problems that existed during the screening on 5/5/20 at the 7-3 shift change, as well as the PPE that was found in the East Stairwell. It was stated that the West II Unit Manager, RN #2 stated she provided a teachable moment to CNA #3 that failed to wash his hands after disposing of waste in the dirty utility room, before interacting with residents. They stated RN #2 also shared with them that the housekeeper did not remove gloves, wash hands and re-apply a new set after emptying trash between rooms where Resident's #1 through #8 resided.